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PAYMENTS OF PHYSICIANS BY THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MAY 24, 1988

Serial 100-71

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
90-926 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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PAYMENT OF PHYSICIANS BY THE MEDICARE PROGRAM

TUESDAY, MAY 24, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:35 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, MAY 4, 1988

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON PAYMENT OF PHYSICIANS BY THE MEDICARE PROGRAM, TO BE HELD ON TUESDAY, MAY 24, 1988

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on payment of physicians by the Medicare program. The hearing will be held on Tuesday, May 24, 1988, beginning at 10:30 a.m., in room B-318 Rayburn House Office Building.

The hearing will include testimony from Dr. Philip R. Lee, Chairman of the Physician Payment Review Commission (PPRC), Dr. William L. Roper, Administrator of the Health Care Financing Administration (HCFA), and representatives of physician organizations. Dr. Lee's testimony will focus on the Physician Payment Review Commission's second annual report to Congress.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

Medicare pays for physician's services on a fee-for-service basis. The Medicare-approved charge for a service is set at the lowest of the physician's actual or customary charge or the prevailing charge in the locality. This mechanism has changed remarkably little since enactment of Medicare in 1965.

Recently, there has been increasing awareness of the need for fundamental reform of physician payment under Medicare. Major concerns focus around three issues: rapid increases in program costs, high out-of-pocket costs for the elderly, and significant inequities in payment allowances.

To assist in developing a strategy for payment reform, Congress established the Physician Payment Review Commission in 1986.

On March 31, 1988, the PPRC submitted its second annual report to Congress. The Commission's principal recommendation is that Medicare payments should be based on a fee schedule which in turn would be based on a resource-cost relative value scale (RVS). Over the next several months, the Commission will review the RVS being developed by Professor William Hsiao at Harvard University, and will make final recommendations concerning the RVS in its March 1989 report to Congress.

The Commission also examined a range of options to increase physicians' willingness to accept the Medicare-approved charge as payment-infull and to limit extra charges to beneficiaries in other cases. It is expected that the Commission will make specific recommendations on this issue next year.

Finally, the Commission recognizes that a fee schedule alone is insufficient to moderate the growth in Medicare expenditures. Accordingly, the Commission has begun to examine a range of options aimed at reducing the provision of unnecessary services. These options include: improvements in utilization review by carriers and peer review organizations (PROs), educational strategies involving the use of practice guidelines, and the use of area-wide expenditure targets similar to those used in Canada and a number of European countries.

These and other issues will be considered during the hearing on May 24.

WRITTEN STATEMENTS FOR THE RECORD:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, June, 10, 1988, to Robert J. Leonard, Chief Counsel Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing may be submitted in other forms.

Chairman STARK. The Subcommittee on Health will begin its hearing. And today we will focus on physician payment reform under Medicare.

Consideration by Congress of physician payment reform began in 1984, triggered by the need to get budget outlays under control.

Congress should have two primary goals for physician payment reform. First, the elderly must be assured access to medical care of the highest quality at a cost they can afford. Second, program costs must be affordable for the taxpayers as well.

Medicare generally has succeeded in meeting this first goal. Twenty-five years ago many elderly were forced to receive charity care. Now most have ready access to the best care available in the country. With the success of the participating physician program, assignment rates are now at an all time high. More than 76 percent of claims are now assigned, up from 51 percent 10 years ago. As a result, the growth in extra billing has slowed, and medical care is now more affordable.

Nonetheless, we can and should do better. Assignment and participation rates are too low in several parts of the country. As a practical matter, the elderly often do not have an opportunity to select a participating physician in advance. This is particularly true in the case of emergency services, or in the case of referral services such as radiology, anesthesiology, and pathology.

Physician payment reform will have little meaning for the elderly if Congress fails to take aggressive steps to reduce extra billing.

The biggest remaining problem that Congress needs to confront is controlling the program costs for the taxpayers. Total payments for physician services have been growing at an annual compounded rate of 15 percent a year, primarily due to increases in volume.

One promising approach to the outlay issue would be to follow the Canadian system. There, Provincial governments negotiate with the local medical societies for annual global fee updates. By taking into account projected increases in volume, the process serves to establish an overall annual budget for the government. After establishing this global update, the physicians themselves negotiate for specific fee amounts. Physicians accept those negotiated fees as payment in full, and extra billing is not allowed.

The system appears to work. Doctors and government both appear to be generally satisfied with the process. Of course there are a lot of differences between Canada and the United States, so that system might not be directly applicable. But one thing is clear: Any serious proposal for physician payment reform must deal squarely with the problem of the rapidly increasing outlays; otherwise, the spiralling of costs will continue, and Congress will be forced by budgetary pressures to respond with a new round of freezes and cuts.

I want to point out that this committee, on a bipartisan basis in the past two Congresses, has been responsible for lifting freezes, and increasing payments, and making an attempt to keep promises made by prior administrations and Congresses. It is not with this subcommittee, with which some physicians have to argue that we did not keep faith. And as a matter of fact, it was this Chair's first statement, I think, when I was first on this committee, that we would never be able to negotiate with the physicians unless we kept in place intended increases.

Part of the reason that this committee, I think, has been so successful in its legislation is in the excellent cooperation and foresightedness of our ranking member, Mr. Gradison, whom I am sure has a few words for us at this point.

Mr. **Gradison**. Thank you for those kind words, Mr. Chairman. I am delighted this hearing is taking place.

It seems to me that the question of physician reimbursement under Medicare is about where we were with hospital reimbursement in 1983, and that there are options that we are going to have to consider in the years immediately ahead which reflect a fundamental restructuring in the way in which these payments are made. Unless one believes that the market is working perfectly in the way in which such fees are established and in the way differentials are set among groups of physicians—and I do not happen to think the market is working with such ideal perfection—we have no choice but to confront these difficult issues.

This hearing, therefore, I assume, is the beginning of a long road. My great hope is that we can find a way to deal with these issues, as, initially, we were able to with hospital reimbursement, which is not as confrontational and as abrasive as many seem to expect that n issue like this has to be.

Whether the Canadian experience is appropriate here or not, one thing that certainly impressed me on our visit to Canada is that over the years, while there certainly has not been unanimity on every point, and indeed, there had been two doctor strikes in the province of Ontario, overall, there has been an acceptance of common goals and a willingness to work together to deal with these issues. And if we can only learn how to do that, I think we will have made an enormous step forward in improving the way in which physician reimbursement under Medicare is actually implemented.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you. Mr. Coyne.

Mr. **Coyne**. I have no statement.

Chairman **Stark**. Our first witness will be Dr. William Roper, Administrator of the Health Care Financing Administration who will discuss with us the problem of volume and expenditure growth.

As always, Bill, it is a pleasure and a privilege to have you here. And your prepared statement will, without objection, appear in the record in its entirety, and you may summarize, expand on it, or review it with us in any manner you choose.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Roper**. Thank you, Mr. Chairman, members of the subcommittee.

I will summarize my statement. What I hope to do in my testimony and in response to your questions is provide a context for your discussion with other witnesses yet to come.

Among them are Phil Lee, my colleague, who is Chairman of the Physician Payment Review Commission. The Commission's work has been very important to us, and our staffs have worked together closely in the work of the Commission.

And I hope to convey contexts as to how we are currently administering the program, and the obstacles that we see for the future.

I appreciate the points that both you and Mr. Gradison made about the important spirit of cooperation as we enter into and debate physician payment reform under Medicare, and I will surely carry that on.

But I will speak plainly as well, because I think it is important that we understand what the real facts are as we deal with these important issues.

Medicare physician spending has been increasing rapidly. That is not a new phenomenon. Between fiscal year 1975, and last year, 1987, Medicare physician payments increased almost four times as much as overall domestic Federal spending.

Over the next 10 years, even without any program expansions, we project that Medicare spending for physician services will triple.

Furthermore, between the years 2005 and 2010, in part because of the rapid increase in physician spending, total Medicare spending is expected to exceed spending on Social Security, making Medicare the country's largest entitlement program.

So I will pass Dorcas Hardy by that time as administering the largest Federal entitlement program. To put it plainly, Medicare physician spending has been and will continue to be out of control.

Medicare part B outlays are financed, as you know, one quarter by premium, three quarters by Federal general revenue. There is not a threat of bankruptcy to this trust fund, because the Federal general fund revenue is always there to continue funding ever larger amounts of spending under the program.

Previous Congresses, previous administrations, this Congress and this administration, have dealt with this issue, with price restraint, fee freezes, proposals for capitation, and enrolling beneficiaries in private health plans. The latter, I believe, is our long term best hope for dealing with this problem.

But we don't have an effective mechanism to constrain the rapid growth in physician spending in the near term, and this extraordinary growth places real pressure on you and us. I think we all need to work together quickly to come to grips with the problem.

What I hope to do, as I said, is bring some perspective to this debate. I want to talk about the problems we face in physician payment, contrasted with hospital payment; discuss the issues of prices that we pay physicians, and how that is intertwined with volume and intensity questions, effectiveness and access questions; and finally, suggest where we go from here.

First, the question of hospitals and doctors, and comparing and contrasting. We have been generally successful in constraining growth in hospital payments under the Medicare program.

Five years ago last month you enacted the hospital prospective payment system, and that has worked with large success in constraining, and I believe, in fundamentally improving, though not in a permanent sense, the way we pay hospitals under Medicare.

But there are significant differences between physicians and hospitals. First, a hospital DRG encompasses a bundle of services. It is everything that happens to a patient in the hospital; an entire episode of care.

By contrast, the unit of payment for physician services is the individual procedure or service. We have 475 DRG's under which we pay hospitals. We have roughly 7,000 different procedures and services for physicians.

Second, we deal with 500,000 physicians and 7,000 hospitals, so the sheer magnitude is an important difference.

Also, the number of bills is strikingly different. We have for next year projected about 350 million bills under part B for physician services, contrasted with 11 million for hospital services.

And finally our data systems for physician services are much cruder than our data systems for hospital services.

To summarize, the task of monitoring 11 million admissions from 7,000 hospitals for 475 DRGs pales in comparison with that of reviewing 350 million bills from 500,000 physicians for 7,000 different procedure codes.

That is reality, and that is what I hope to encourage you all to focus on in the debate that will unfold in the months and years ahead.

There are substantial issues at hand in the question of physician payment reform. We believe the important goals are: First, to improve efficiency and establish fairer relative prices across physician services.

Second, to provide incentives for appropriate utilization and cost containment.

Third, to help assure that high quality and effective medical care is delivered, and that ineffective treatment is discouraged.

And fourth, to ensure that beneficiaries have access to services.

Those are ambitious goals. Sometimes they conflict. We need to keep them in focus.

First, the question of price. One approach to changing the Medicare physician payment system which has been advanced by the Physician Payment Review Commission, a number of my colleagues in the medical community, and some Members of Congress, would be to substitute the current fee-for-service payment system with a fee schedule obtained from a resource based, relative value scale, an RVS system.

The Medicare statute has required us to present you with a report a little over a year from now, in July of 1989, on how we would implement such a fee schedule based on an RVS.

For the last 2 years we have had a cooperative agreement with Harvard University to study this matter, and we anticipate their final report this summer. Thirty days after we get it, we will release it publicly to PPRC and to anybody else who is interested in it, along with the data tapes that lie behind that report, because we think it is important that it be evaluated fully.

My boss, Secretary Bowen, a family practitioner, and I as a pediatrician, are clear on one point: The so-called cognitive specialities like ours are underpaid, under valued, under rewarded, whatever word you want to use, in comparison with the procedure-oriented specialties.

We ought to be paid more; the surgeons ought to be paid less. Let us get that on the table at the outset.

As a matter of fact, last night I dug out of my memorabilia file my certificate from the American Board of Pediatrics, and started to bring it to you. I decided that would be a little hokey, even for me.

But anyhow, no question about the issue of price equity.

My concern on the RVS, though, is that it has taken on the aura of a magic bullet. People talk about it as if it is the solution to all the problems we face in physician payment under the Medicare program.

Let me give you an example. I have talked with a number of Members of Congress about the substantive physician payment issues, and I explain our concern about volume growth and a number of other things of that sort, and then I get a response that goes something like this: "Well, when is that Harvard study going to be done? "

And the implication that lies behind that, and I do not mean to be disrespectful, is: "You get the Harvard study, we will get it from you, and that is the answer to the problems."

And what I am here today to tell you is that the study is an important undertaking, and I believe in price equity as much as anybody else. But there are a lot of other issues that the study does not touch on.

Also, I would like to explain that we are going to be looking carefully at the potential redistributive effects of an RVS fee schedule, how the money gets shifted around. In 1990 we estimate it would cost about $850 million to raise payments for all medical visits—that is internists, family practitioners, and so on—by 10 percent. Ten percent seems like a reasonable amount to start to increase internists' and family practitioners' fees; but it would cost $850 million.

To finance that in a budget neutral fashion would require a 16-percent across-the-board reduction in payment for surgical services. So the surgeons would take a 16 percent hit, in order to give medical visits a 10-percent increase.

Or you could finance it with a 9-percent reduction in payments for all physician services other than medical visits—that is, adding in the radiologists and pathologists and whatever.

It would cost $400 million to raise payments for primary care medical visits by 10 percent. To finance this in a budget neutral way would require either an 8-percent decrease in payments for surgical services, or a 4-percent decrease in payments for all physician services other than medical visits.

My point is a simple one: These are not trivial amounts of reductions that have to accompany the increases if this is going to be done in a budget neutral fashion.

Everyone on my side of the debate—and again, I am a pediatrician—is interested in levelling up. I think some people in the Congressional Budget Office and OMB and elsewhere are going to be interested in levelling down. And let us just not obscure that tradeoff as we go about the question of price equity.

And the point that I would put before you is a simple one. Is it worth investing the lion's share of our analytical, administrative, and political resources to substitute one fee-for-service payment system for another, leaving Medicare's most important issue, increased volume and intensity, untouched.

I would urge you to consider that as you go about this debate.

A further point I would make is that a reformed payment system, once you set these prices, is not going to stay fixed. Somebody is going to say, well, mine ought to be higher, or his ought to be lower.

And you are going to have a train of witnesses before you, just like you have had from my friends in the hospital community, saying that Illinois ought to be higher or lower, or Alabama's ought to be higher or lower.

And you are heading, if you head in this direction, down a road that is going to mean continual debates over relative prices.

Perhaps you would assign that authority to the Health Care Financing Administration; we would appreciate that. But nonetheless, there are going to be debates over price equity continuing over time.

My purpose in raising this is not to say that an RVS fee schedule is a crazy idea or a stupid idea; but it is to say, understand the larger context.

Let me turn to a point I have mentioned several times, and that is the question of volume and intensity.

Over the last 10 years, volume and intensity increases, which reflect new services and technology, accounted for about half the increase in Medicare physician spending per aged enrollee.

The volume and intensity increases have accounted for 6.6 percentage point increases in Medicare physician spending per year over the last 10 years.

This is not a new issue, not a new phenomenon; it is, however, a longstanding one. Price increases and population growth account for the other half of the increase in spending.

The enormous growth in volume and intensity is reflected in the growth in physician spending relative to the general economy, and to the Federal budget. Over the last 12 years, Medicare physician spending per beneficiary increased at a compound annual rate of 15 percent, or almost twice the compound annual rate of the growth in per capita GNP.

Let me be careful to point out that this is over the last 12 years. This is not a post-PPS phenomenon. This didn't just happen in 1984. This is a longstanding growth in services.

Much of the increase in volume and intensity has gone to provide real benefits for patients, and there is no debate over that. These are good things happening for people who need the services.

But there also is considerable unnecessary utilization of services. You are going to be hearing from Mark Chassin later this morning. He and others have done a lot of work in this area, which I will get back to in just a few minutes.

We are sponsoring several major studies examining the source of the increase in Medicare physician spending over the last several years. We are looking at such things as consultations, anesthesia services, the costs of diagnostic tests, cataract surgery in particular, assistants at surgery, and global fees for surgery.

INTENTIONAL
BLANK

We have looked in more detail at spending between the years 1985 and 1986. Let me give you some preliminary data from our work there. Over that period, from 1985 to 1986, expenditures for surgical services increased 19 percent; expenditures for consultations increased 20 percent. For lab and radiology services, 23 percent; and for anesthesia services, 14 percent.

There have been major increases in volume and in intensity, even after you account for price increases.

Now, people have asked thoughtful questions to probe more deeply into this issue. And my answer to you last September 30 and to others who have asked these questions is, we do not have fully satisfactory answers to all the questions.

Part of the reason that it is difficult to disentangle all of this is, a lot of things have been changing at the same time. Over this period, the last 5 or so years, Medicare physician fees have been frozen; the participating physician program has been implemented; we have had a direct billing requirement and fee schedule for lab services; the hospital prospective payment system was implemented; the PRO program was begun; several billing changes, including a common procedure coding system was implemented; non-Medicare hospital admissions decreased; the supply of physicians increased substantially; and market competition from HMOs and other alternative delivery systems grew.

A lot of independent variables, if you will. And I just have to tell you, we are not able fully to disentangle all of that.

But, in summary, we believe that the growth in volume and intensity indicates that we face substantial problems in controlling the overall growth in physician expenditures.

I am not bashing doctors. Some of my good friends are doctors, including my wife. This is not an issue of us against them. It is an issue of where do we go in the debate about physician services under the Medicare program.

There is an argument that I think is important to deal with, and that goes something like this. "Well, there are so many problems in the way we pay physicians under Medicare. At least if we can be fairer in the unit pricing of these services, then my physician colleagues will perceive this system as being more fair, and they will be more willing to undergo the other changes that are necessary to deal with the problem."

That is a valid argument. But again, I would just urge you to pay attention to the larger context in understanding what you are doing and debate the question of a fee schedule.

Let me turn to the question of effectiveness of services. It is important that we pay for services that are clearly effective, and shown to be so by good medical evidence.

There is a growing body of medical evidence that shows that we pay for a lot of things that are not effective. As I said, Mark Chassin and his colleagues have looked at this issue, and they found that 17 percent of coronary angiograms and upper gastrointestinal endoscopies and 32 percent of carotid endarterectomies are inappropriate.

David Eddy and others have looked at the medical evidence for a great number of widely accepted medical procedures and found that to be limited.

We in the Department strongly believe that additional information is needed so that physicians can choose effective treatment, because I believe that is what they want to do. They want to practice good medicine.

And we in HCFA are taking a leadership role in developing that information and making it available to physicians. We are doing it in partnership with the Public Health Service, and seek wide participation from the medical community in this endeavor.

We have initiated a number of activities in this regard, looking at the effectiveness of several procedures, including coronary revascularization, cholecystectomy, and prostatectomy. We are using information from about 30,000 medical records supplied by eight peer review organizations.

We will also look at various interventions for myocardial infarctions, heart failure, and pulmonary disease, a whole host of things.

What we want to do is use the data at hand from Medicare claims and clinical data to do initial studies that can then be referred to other researchers to look more carefully at what works in the practice of medicine.

These studies will produce better information on the risks and benefits of medical practices and procedures.

We are developing better data files. In fact we published just a couple of weeks ago a notice in the Federal Register offering our hospital data base to the wider public for research of this sort.

We are about to link up with the National Cancer Registry for research data on cancer treatment.

Better information on the effective practice of medicine will yield a benefit that Secretary Bowen is actively interested in, that is, better information for doctors to practice and protect themselves against the threat of malpractice. One of the problems in the malpractice area is ill defined standards of practice. And I think this offers real hope to doctors in this area.

Finally, a key issue in any Medicare physician payment policy is the question of access and financial protection for beneficiaries. If a fee schedule is put in place at some time in the future that diverges significantly from the private market for physician services, there will be the potential for restricting access of Medicare beneficiaries to such services.

We have a program, the PARDOC program, that we think is working well. We now have 34 percent of physicians who have signed the participating agreements. They render 52 percent of services on a dollar basis.

A total of 76 percent of physician services are provided under assignment. I think there is a way to protect beneficiariies in place now.

Where do we go from here? You have heard me talk many times before about our belief that capitation, payment of overall amounts to private health plans, offers the best way of providing appropriate incentives to deliver quality services to beneficiaries.

That is not going to solve the problem tomorrow. While we are looking towards that, we believe in the shorter term we need continued limitations on annual increases in physicians' fees; targeted reductions at overpriced procedures; and increased utilization review activities.

UR, utilization review, is something that is gaining increased visibility, and we plan to invest more heavily in this area. We also seek to launch a series of preferred provider organization demonstrations, and we plan to study the question of effective practice of medicine more, as I said a few moments ago.

Let me just finally say, coming up with price equity in how we pay physicians is worth important debate, but it is not a panacea to the problems we face in the Medicare part B program.

We should not allow the debate over an RVS fee schedule to sidetrack us from the larger problem.

Much of the spending for physician services in Medicare is for services that provide real benefit to senior citizens, but I think we need to have an even larger debate, and that is over the question of whether the burden of proof ought to be on us, as it is now, to say that something is not worthwhile before we stop paying for it, or whether we want to transfer that burden of proof.

As it is now, we have an unspoken premise that more services are better until there is overwhelming evidence to the contrary.

Perhaps the most important question before the Congress and the Administration is whether that presumption in favor of more spending makes sense, especially in a time of limited resources, and the tradeoffs that we face.

I do not claim that there is an easy answer to any of these vexing problems, but in light of the rapid growth of Medicare physician spending, we need to ask ourselves: "Are American taxpayers and Medicare beneficiaries getting the best value for their dollars?"

I believe the answer to that is no. We can, and we must, do better.

With that, I would be pleased to answer your questions.

[The statement of Dr. Roper follows:]

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss Medicare physician payment.

We are all aware that Medicare physician spending has been increasing rapidly. Between FY 1975 and FY 1987, Medicare physician payments increased almost four times as much as overall Federal domestic spending. Over the next 10 years, even without any program expansions, we project that Medicare spending for physicians' services will triple. Furthermore, between the years 2005 and 2010, in part because of the rapid increase in physician spending, total Medicare spending is expected to exceed spending on Social Security, making Medicare the country's largest entitlement program. To put it plainly, Medicare physician spending has been -- and will continue to be --- out of control.

Unlike Social Security and Medicare Part A, programs for which outlays are constrained by earmarked taxes, Medicare Part B outlays are financed through an open tap to the Federal Treasury. This means that even though there is a crisis in Part B expenditure growth, there is no threat of bankruptcy to the Part B Trust Fund.

During the past 15 years, Congress and several Administrations have tried to control growth in physician spending in two major ways. First, we have used price restraints and fee freezes. While these steps may have slowed the growth in physician spending, increases continued at double-digit rates. Second, we have tried to control physician spending by making capitation payments to private health plans. I believe this approach has substantial long-run potential for containing costs, but the major changes required in service delivery and financing will limit its impact on overall spending for some years.

In short, the Federal government does not have an effective mechanism to constrain the rapid growth in physician spending in the near term, and yet this growth places strong pressure on us all to do precisely that. It will not be an easy task.

To help bring some perspective to the issue of Medicare physician payment policy, I will:

- Illustrate the difficulty of changing physician payment policy by drawing a comparison to payment policy for hospitals;
- Discuss the intertwined issues of price; volume and intensity 1/; effectiveness; and access; and
- Suggest where we go from here.

Comparicon of Medicare Physician and Hospital Payment Policy

After our generally successful reform of Medicare's hospital payment system, many wonder why we cannot do the same for Medicare payment of physicians. Significant differences between physicians and hospitals, however, make physician payment changes far more difficult.

- Hospital DRGs represent payments for the bundle of services associated with an entire episode of care -- the hospital stay. By contrast, the unit of payment for physicians is an individual procedure or service. Our payment system recognizes roughly 7,000 different procedures and services for physicians, compared with only 475 DRGs for hospitals.

- There are about 500,000 physicians, compared to about 7,000 hospitals in America, and there are many different physician specialties and types of practice. While hospitals can average their PPS gains and losses across

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1/ In the remainder of my statement, the term "volume and intensity", refers to all factors not explained by price and population changes, including new services and technology.

many cases, physicians' smaller caseloads and greater specialization make averaging gains and losses much more difficult. The impact of changes in Medicare payment on individual physicians could be problematical.

- o The sheer number of bills for physicians' services is staggering. In FY 1989, we expect to process about 350 million such bills compared to 11 million inpatient hospital bills. And we need to review the bills and make sure they are appropriate.
- o While we have made major strides in the past few years in upgrading Part B data, our national physician data bases do not yet have the detail and comprehensiveness of hospital data bases.

To summarize, the task of monitoring 11 million admissions from 7,000 hospitals for 475 DRGs pales in comparison to that of reviewing 350 million bills from 500,000 physicians for 7,000 different procedure codes. These differences mean that substantial changes in how we pay physicians will be vastly more difficult to implement than the changes we have made in hospital payment policy.

Issues in Medicare Physician Payment Policy

Any proposal for reform of Medicare physician payment policy should be evaluated in terms of several fundamental goals. They are: (1) to improve efficiency and establish fairer relative prices; (2) to provide incentives for appropriate utilization and cost-containment; (3) to help assure that high quality and effective medical care is delivered while discouraging ineffective treatments; and (4) to assure that beneficiaries have access to services.

These are ambitious goals, and they may sometimes conflict. In short, they may be referred to as the issues of price, volume and intensity, effectiveness, and access. I will discuss each in turn.

The Issue of Price

One approach to changing the Medicare physician payment system, which has been advanced by the Physician Payment Review Commission (PPRC), some in the physician community, and some members of Congress, would be to substitute for the current system of setting prices a fee schedule obtained from a resource cost based relative value scale (RVS).

The Medicare statute requires that HCFA develop and report to Congress on a relative value scale by July 1, 1989. For the past two years we have had a cooperative agreement with Harvard University to study this matter, and we expect the final report this summer. We will do everything possible to assure that the report is completely documented and clear to both general and technical audiences. Thirty days after we receive the final report, we will make it and the data tapes available to PPRC and anyone else who wishes to study them.

From our point of view, it is too early to judge the Harvard RVS. We want to assure that the study is as scientifically valid and reliable as possible. As part of our report to Congress, we plan to analyze the technical aspects of the Harvard study. We understand that PPRC and other groups also plan to analyze it.

Secretary Bowen, as a family practitioner, and I, as a pediatrician, share the concern that cognitive or primary care services are relatively underpaid and that the more procedure-oriented services are relatively overpaid. Investigating that relationship is one of the goals of the Harvard study.

We are concerned, however, that some people have already accepted the Harvard RVS as a "magic bullet," capable of solving all the problems of Medicare physician payment. While an RVS might help to correct some of the perceived inequities on the price side, the critical issue of volume and intensity will remain, as with any fee schedule. Moreover, income redistributions resulting from an RVS could exacerbate the Part B volume and intensity problem if physicians respond to fee reductions by increasing their volume or intensity of services.

As part of our report to Congress, we will analyze thoroughly the redistributive effects of basing payment on the Harvard RVS. For the present, however, I would like to provide some suggestions of the magnitude of the redistributions that an RVS might produce.

- In 1990, it would cost about $850 million to raise payments for all medical visits by 10 percent, a modest increase compared to expectations in some segments of the physician community. To finance this increase in a budget-neutral way would require either: (i) a 16 percent across-the-board reduction in payments for surgical services, or (ii) a 9 percent reduction in payments for all physicians' services other than medical visits. (These figures reflect the increases for volume and intensity typically assumed by the HCFA actuaries and the Congressional Budget Office as a behavioral response to payment reductions.)
- It would cost $400 million to raise payments for primary care medical visits by 10 percent. To finance this in a budget neutral way would require either: (i) an 8 percent decrease in payments for surgical services, or (ii) a 4 percent decrease in payments for all physicians' services other than medical visits.

Needless to say, bigger payment increases for visits would require deeper reductions in payment for other services in order to maintain budget neutrality. Given the budget deficit, however, it may be necessary to achieve budget savings from a fee schedule, which would require even deeper cuts in payment for the affected specialties.

The question I would ask proponents of fee schedules to reflect upon is: "Is it worth investing the lion's share of our analytical, administrative, and political resources to substitute one fee-for-service payment system for another, leaving Medicare's most important issue -- increased volume and intensity -- untouched?"

We need also keep in mind that the "reformed" payment system will not stay "fixed". Inevitably, the losers will seek to reopen old issues -- much as hospitals have done under PPS. Refighting old battles will multiply the analytical, administrative, and political burden, distracting our attention from the need to address issues other than perceived inequities in price.

My purpose in raising these questions is to focus attention on the "full cost" of an RVS-based fee schedule. Perhaps perceived inequities could be addressed with more incremental steps, such as differential annual updates for primary care services and targeted reductions in overpriced procedures -- approaches that were enacted in OBRA-1987. In this context, we may be able to use an RVS to help us identify additional overpriced procedures.

The Issue of Volume and Intensity

Regardless of how the price issue is treated, the separate and now more pressing issue of increasing volume and intensity must be addressed.

Over the last 10 years, volume and intensity increases, which reflect new services and technology, accounted for about half the increase in Medicare physician spending per aged enrollee (about

6.6 percentage points per year). Price increases and population growth account for the other half of the increase in spending. Changes in the volume of services include both increases in the utilization of services and fragmentation of services (which occurs when services that were formerly bundled and billed together are now billed separately). Changes in the intensity or mix of services include both changes in services and changes in coding practices.

The enormous growth in volume and intensity is reflected in the growth in physician spending relative to the general economy and the Federal budget. Between FY 1975 and FY 1987, Medicare physician spending per beneficiary increased at a compound annual rate of 15.0 percent or almost twice the compound annual rate of growth in per capita GNP (7.9 percent). In FY 1990, Medicare is projected to spend an estimated $27.1 billion on physicians' services, more than the entire budget for the Department of Education. And over the next five years, the Federal government's contribution to financing the Part B program is expected to be $175 billion, $25 billion more than the entire Federal contribution to Part B during Medicare's first 21 years.

While much of the increase in volume and intensity has gone to provide real benefits for patients, there is considerable unnecessary utilization of services. Numerous studies of geographic variation in the utilization of services have raised significant questions about the appropriateness of many of these services, a subject on which I will comment more extensively later.

The Department is sponsoring several major studies examining sources of the increase in Medicare physician spending during the past few years. In addition, I have recently initiated studies of specific aspects of Medicare physician spending including consultations; anesthesia; the costs of diagnostic tests such as x-rays and EKGs; cataract surgery; assistants-at-surgery; and global fees for surgery.

To provide some perspective on increases in volume and intensity, I would like to share some preliminary data on the growth of Medicare physician spending between 1985 and 1986. Expenditures for surgical services increased 19 percent; expenditures for consultations increased 20 percent; expenditures for lab and radiology services increased 23 percent; and expenditures for anesthesia services increased by 14 percent. Even after accounting for price and population changes, these preliminary findings indicate major increases in volume and intensity in certain areas of physician spending.

It is difficult to isolate the exact cause of the recent increases in Medicare payments to physicians because of the many changes occurring at the same time in the public and private sectors. For example, the following changes could have affected physician spending over that period: Medicare physician fees were frozen; the participating physician program was initiated; a direct billing requirement and fee schedule were implemented for lab services; the hospital PPS was implemented following the TEFRA per admission limits; the PRO program was implemented; several billing changes, including the implementation of a common procedure coding system, occurred; non-Medicare hospital admissions decreased; the supply of physicians increased; and market competition from HMOs and other alternative delivery systems grew.

In summary, we believe that growth in volume and intensity indicates that we face substantial problems in controlling the overall growth in physician expenditures. Let me emphasize that these are not problems of price, and a relative value scale, no matter how carefully constructed, cannot be expected to deal with them. Fee-for-service systems do not provide physicians with incentives to control the volume and intensity of services. The volume and intensity problem would remain under an RVS-based fee schedule, and it could even get worse if physicians whose payments are lowered attempt to recoup their lost income by increasing the volume or intensity of services.

The Effectiveness of Services

We believe that the Medicare program should strive to pay for services that are clearly effective as shown by good medical evidence, while discouraging ineffective services. This task is challenging because of the growing body of knowledge suggesting there is much uncertainty about the effectiveness of many medical procedures.

Let me provide you with a perspective on the current status of effectiveness research and the goals of the Department in developing further information in this area.

Mark Chassin and his colleagues at the RAND Corporation examined the appropriateness of three procedures performed on Medicare beneficiaries in high, average and low use areas and found that as many as 17 percent of coronary angiograms and upper gastrointestinal endoscopies and 32 percent of carotid endarterectomies were inappropriate. (Another 32 percent of carotid endarterectomies were classified as "equivocal," meaning that there was question or disagreement as to whether the procedure was appropriate for the specific indication). The researchers concluded that the geographic differences in the utilization of services cannot be fully explained by differences in the proportion of appropriate procedures across geographic areas. (That is, the proportion of appropriateness and inappropriateness were often similar in high-and low-use areas). The researchers also found that 10 percent of patients who underwent carotid endarterectomy experienced major complications afterward.

Finally, in a recent article in Health Affairs, David Eddy and John Billings at Duke University point out that the medical evidence for a great number of widely accepted medical practices is very limited. They recommend that the medical profession examine the scientific basis of medical practice more closely and use this information to establish appropriate practices.

The Department strongly believes that additional information is needed so that physicians can choose the most effective medical treatment, and HCFA is taking a leadership role in developing this information and making it available to physicians. We will do this in partnership with the Public Health Service, and we especially want the wider medical community to be actively involved.

HCFA has initiated a number of activities in this regard. We are currently analyzing the effectiveness of several procedures, including coronary revascularization, cholecystectomy and prostatectomy, using information from 29,000 medical records supplied by eight Peer Review Organizations (PROs). We will also look at various interventions for myocardial infarction, heart failure, and pulmonary disease. After adjusting for severity of illness, we will attempt to assess the impact of these interventions on mortality, morbidity, disability, and overall expenditures. And we are continuing analyses of variations in medical practice, re-hospitalizations, mortality patterns and outcomes across geographic regions and within small geographic areas.

We are, in short, developing the ability to use Medicare claims and clinical data to do initial phase studies of what works in medicine. These studies may not provide definitive evidence about potential benefits to individual patients, but we can use them to develop better information on, for example, death or reoperations. These studies will produce better information on the risks and benefits of medical practices and procedures. Better documentation of risks and benefits is especially important when ever larger sums are being spent on new and purportedly better services.

One of the obstacles in effectiveness research has been the lack of a data base that encompasses information on all care that is furnished to a patient. We have devoted significant resources to developing a new Part B data base, known as the Part B Medicare Annual Data System (BMAD). This system is comprised of a file of all the services provided to a sample of beneficiaries; a file of all the services furnished by a sample of physicians and suppliers; and a file of prevailing charges and spending for all procedure codes.

We have also compiled a hospital admission data base, known as the Medicare Provider Analysis and Review (MEDPAR) file, that permits analysis of patient outcomes. We used the MEDPAR file to conduct our December 1987 study of hospital mortality rates. And we have recently published a notice in the Federal Register offering this file to a broad group of researchers for additional medical effectiveness studies.

Finally, we will also be enhancing the Medicare statistical system this Fall by linking it to the National Cancer Institute registry. Over half of all cancers and 65 percent of all cancer deaths are found in the Medicare population. A combined data base will permit studies of cancer patients that can link diagnosis, stage of cancer, treatment plan, site of care and expenditures, to specific patient outcomes.

HCFA has a responsibility to assure that Medicare beneficiaries receive care of the highest quality. We believe that our active role in effectiveness research will help generate additional information on which the medical community can build consensus on appropriate medical practice. We believe that physicians are eager for such information and would voluntarily use it.

Better information on effectiveness may, in fact, help alleviate our nation's "malpractice problem," a long-standing goal of Secretary Bowen's. As you know, malpractice litigation may turn on whether or not the physician adhered to the "standard of practice" for treating a patient with a given set of symptoms and test results. All too often, however, the standard of practice is ill-defined or based on weak evidence. In such cases, malpractice litigation can dissolve into an unseemly battle of lawyers and expert witnesses. Better information on effectiveness may ultimately lead to clearer, better-documented standards of practice. In the long run, those standards could help us avoid unnecessary litigation and rationalize litigation that does occur.

The Issue of Access

Finally, a key issue in any Medicare physician payment policy is beneficiary access and financial protection. Most physicians treat Medicare patients, and Medicare has done a good job of assuring access and providing financial protection for beneficiaries.

Given that Medicare has only a 21 percent share of the physician services market, any fee schedule which diverges significantly from current rates will increase the risk that physicians could: (i) reduce the provision of certain services or procedures to Medicare beneficiaries, and/or (ii) decrease assignment and participation rates.

Some may use the debate on a Medicare fee schedule to press for mandatory assignment, arguing that physicians should not be allowed to charge more than the socially determined "right" prices established by an RVS-based fee schedule. We believe that mandatory assignment could reduce access to services from some physicians, and could lead other physicians to increase the volume or intensity of services they provide. Moreover, mandatory assignment is unnecessary because the voluntary participating physician program has worked well in increasing assignment rates. During the first quarter of 1988, the assignment rate for physicians' services (based on dollars) was 76.3 percent, and the 34.4 percent of physicians who signed participation agreements rendered services accounting for 52.4 percent of total physician spending.

Where Do We Go From Here?

We believe that making capitation payments to private health plans offers the greatest promise for successful long-term reform of Medicare physician payment. Capitation provides appropriate incentives to control both the price and quantity of services. Placing decisions regarding fee levels, utilization review, and selection of preferred providers in the hands of plan administrators and physicians allows each plan to deal with these issues as it deems best at the local level, and encourages providers to deal with both price and utilization. Moreover, private health plan options offer beneficiaries choices and opportunities for expanded benefit packages.

We recognize, however, that it is unrealistic to expect our private health plan strategy to change the profile of the Medicare program dramatically in the near term. Therefore, we believe we must take more immediate steps to slow the growth in fee-for-service physician spending through continued limitations on annual increases in Medicare physician fees, targeted reductions in payments for overpriced procedures, and increased utilization review activities.

Let me elaborate. For 1988 and 1989, the physician update factor differentiates between primary care and non-primary care services. Cumulatively over these two years, participating physicians will receive a 6.7 percent update for primary care services and 2.0 percent for non-primary care services. Additional years of differential updates could make a significant contribution toward improving payments for primary care services, as well as provide budget savings from non-primary care services, without bringing on the major redistributions and disruptions that might occur from an RVS based-fee schedule. An RVS might be used to help identify additional overpriced procedures for which payment could be lowered. The Administration's FY 1989 budget calls for payment reductions for specified overpriced services.

We believe that additional Part B utilization review activities would also make an important contribution to addressing some aspects of the volume issue. For FY 1989, the Administration has requested an additional $50 million for utilization review activities by the carriers. These monies will enable carriers to implement additional pre-payment and post-payment screens.

Additionally, we are developing a demonstration of Preferred Provider Organizations (PPOs) for Medicare beneficiaries. A PPO will encourage physicians to provide appropriate services through increased utilization review, and will provide beneficiaries with financial incentives to choose physicians with appropriate utilization profiles.

Finally, I mentioned earlier our studies of both overall volume and many specific aspects of Medicare physician pricing and volume. Also, our effectiveness initiative should help provide important information about the appropriateness of services.

I do not want to imply that our efforts will solve the problem of rapidly growing physician expenditures. However, these approaches are needed to slow the growth rate in physician spending and will provide us with key information for dealing with the more important issue of the volume and intensity of physicians' services.

Conclusion

The last 15 years have taught us that while fee limitations could slightly reduce the rate of growth in Medicare physician expenditures, they are not a panacea. While an RVS based on resource costs may reduce perceived payment inequities, an RVS will not do for physicians what DRGs did for hospitals. An RVS would substitute one fee-for-service method for another, and deal only with price. We should not allow the debate over an RVS to sidetrack us from the most pressing problem, the rapid growth in physician spending.

Much of the increase in Medicare spending is for services that provide real benefits to senior citizens. There is growing evidence, however, that significant sums are spent on services that do not help patients. Some may even subject patients to unnecessary risks. Yet this research has had only a limited effect on Medicare policy, because the policy debate is founded on an unspoken premise: more services are presumed better until there is overwhelming evidence to the contrary.

Perhaps the most important question before Congress and the Administration is whether the presumption in favor of more spending makes sense, particularly when every dollar spent on Medicare leaves less for Medicaid, nutritional assistance, housing, education, and numerous other worthy purposes.

I do not claim that there is an easy answer to this question or the many other issues raised in this testimony. In light of the rapid growth of Medicare physician spending, however, we must ask ourselves: "Are American taxpayers and Medicare beneficiaries getting the best value for their dollars?" I believe the answer is, "No." We can -- and must -- do better.

I welcome the opportunity to work with Congress, the physician community and the public in debating these important matters. I would be pleased to answer any questions that you may have.

Chairman **Stark**. If you could just answer your own questions, I think you would solve the problem for us in a far more expeditious fashion than we will be able to.

But let me ask Mr. Gradison if he would like to inquire.

Mr. **Gradison**. Thank you, Mr. Chairman.

Dr. Roper, one thing that struck me during our visit to Canada, with regard to relative payments to physicians for different types of services, as I understood what we were told, is that the changes which were made, and I guess are still being made, were phased in over a long period of years.

This leads me to wonder whether that model might not work here, where instead of cutting anybody, or cutting anybody very much, there might be a freeze for an extended period of time, 10 years or more, perhaps, during which those increases that took place would be for those services that were held to be underpaid, and the others were simply frozen while the others catch up with them.

In a sense, I guess we have started down that road with the admittedly modest increases for office visits, in the recent reconciliation legislation.

Do you have any thoughts about that general phase-in notion?

Dr. **Roper**. I think it makes good sense, practical political sense. Abrupt changes are difficult for everybody to accommodate. Surely it is difficult for physicians to accommodate.

And I think you are more likely to be successful if you go over the long haul.

Mr. **Gradison**. In your testimony you mentioned something I had not heard before—it is very striking—that you project the spending on Medicare will pass Social Security sometime early in the next century.

Did you factor in the anticipated cost of the catastrophic health insurance legislation now pending?

Dr. **Roper**. No, we anticipate under current law—Medicare and Social Security as they are—that this will happen about 2005 or 2010.

If catastrophic passes, as it truly seems it is about to the date will be moved up to the late 1990s. So in about 10 more years, HCFA will be bigger than Social Security.

Mr. **Gradison**. As you may know, we had a weekend long retreat of the Ways and Means Committee, our fifth annual such retreat.

And one of the messages that I carried away from it is that it will be essentially impossible to balance the budget over the next 5 years. I think we are talking about 1993 as just a target date for discussion in those meetings, without very large tax increases, unless the increased cost of health care can be brought in line with the general cost of living.

Dr. **Roper**. You touch on what I think is the big issue. We keep widening the circle, but let me try the widest. It seems to me that we are on the verge of a debate over whether to impose constraints on the aggregate size of the Medicare program. We have not yet decided whether or not we want to do that, and we surely have not decided that if the answer is yes, how we are going to do that.

But I think it would be useful to undertake that first order debate. Because we do not have limits at the present time. We have an open-ended entitlement program.

And let me say again, so I am not misquoted in tomorrow's Post: "It does good things for people that deserve those services."

But right now, we have an open-ended entitlement program, where the burden of proof is on us to say something is wholly useless before we cannot pay for it, or else we have folks saying that we ought to pay for these services that are good for people.

I believe that if we are going to be about the business of imposing restraints, that we ought to move towards private sector control of the constraints, rather than a heavy-handed government approach.

But we have not had the first debates yet whether we as a Nation would be comfortable limiting the size of the Medicare program.

Mr. **GRADISON**. May I ask one final question, Mr. Chairman?

Chairman **STARK**. Please.

Mr. **GRADISON**. Taking advantage of your presence, Dr. Roper, I understand there are plans for limiting the payment for intraocular lenses to somewhere between $200 and $215. As you know, there is some controversy about this number, and various options for payment have been mentioned.

Where does this issue stand in the process? And will you keep the subcommittee informed about it? Because some of this does relate to matters of congressional intent as reflected in OBRA of last year.

Dr. **ROPER**. Surely, we will keep you informed. Where it stands is, we are about to publish a notice of proposed rulemaking requesting comments on this. And I am sure we will get comments all over the map.

We are anxious to pay an appropriate price for services, including intraocular lens replacements.

Mr. **GRADISON**. And what is the normal comment period for a notice of that kind?

Dr. **ROPER**. Sixty days.

Mr. **GRADISON**. Very good. Thank you, Mr. Chairman.

Chairman **STARK**. Mr. Coyne.

Mr. **COYNE**. Dr. Roper, at one point in your testimony you indicated that were we to implement a physician fee plan, we might risk the possibility of decreased participation.

At another point in your testimony you indicate that participation is at a satisfactory level.

I am wondering, if we do go ahead with the fee plan, would that necessitate a mandatory plan?

Dr. **ROPER**. If I am understanding you Congressman, you are saying if the Congress were to pass a fee schedule for physician payment under Medicare, would you at the same time feel compelled to mandate physicians accepting assignment for those claims.

Mr. **COYNE**. In light of your concern that there may be decreased participation as a result of the fee schedule.

Dr. **Roper**. My general concern is that if you change prices significantly, you may have significant numbers of doctors deciding not to be a part of the Medicare program.

I am opposed to mandatory assignment. Let me say that, again, up front. I think the PARDOC program, the participating physician program, is working well. And I would urge you not to impose mandatory assignment.

Mr. **Coyne**. And the specter of decreased participation would not sway your thought on that?

Dr. **Roper**. Well, you are asking a detailed question on something without my knowing what the makeup of the fee schedule is. So my broad, sweeping answer would be no, I would not feel compelled to go along with mandatory assignment.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Thank you.

As usual you are very thorough. In a sense, that is perplexing, because it is complicated.

Dr. **Roper**. If you want the buck to stop here, you need to know the details.

Mr. **Levin**. That is true.

So a couple of questions, trying to disaggregate.

First, were you surprised by the RAND study?

Dr. **Roper**. You mean, the effectiveness-appropriateness?

Mr. **Levin**. Yes.

Dr. **Roper**. I was surprised by the magnitude of their findings, yes, sir. But I think all of us realize that there is substantial art in the practice of medicine, and always will be.

Let me not lead you to believe that it is ever going to be otherwise. But the fact that there is, when judged by respected experts, that much dispute over the appropriateness of services, yes, that was a surprise.

And that builds the argument for why we, as a Nation, need to be investing in research that yields better information on the practice of medicine.

I am trying to generate a little enthusiasm for funding research in a large scale way of that sort. I need some help from appropriations committees and that sort of thing.

Mr. **Levin**. So you consider that avenue an effective one, a promising one, I do not want to overstate it. So while you were surprised, you would not dismiss the results as likely to be wrong.

You find some credibility, as a scientist, endorsing them, you find some credibility in the work?

Dr. **Roper**. Sure. I have a great deal of respect for the folks at RAND, Dr. Chassin, Dr. Brook, and others. If I could just cite one of their articles—maybe Mark was going to do this, but I found it compelling when I saw this yesterday.

An article they published in the Lancet, a British publication, last month, on the standards that experts in the United States and experts in the United Kingdom would apply to coronary artery disease.

They developed a series of hypothetical cases, and said to U.S. experts, do you think this patient ought to have surgery, coronary artery bypass grafting. And then they presented those same hypothetical situations to experts in the United Kingdom. And they got significantly different responses.

And we are not talking about people way out in the boondocks who do not understand the latest, best way to practice medicine. We are talking about nationally recognized experts.

And they got significant differences between the two panels.

The U.S. panel tended, for indications where there was relatively sketchy evidence, the U.S. panel tended to say, yes, we ought to go ahead and do surgery in these cases. In those sort of perplexing midscale cases, the panel from the United Kingdom said, no, we ought not to do surgery. We ought to be more conservative.

Said a different way, the panel in Britain felt strongly that we ought to push medical therapy, nonsurgical therapy, much farther, before you abandon that and go on to surgery, than we do here in the United States.

Who is to say which is right? But it raises the important question that we need to answer so that the doctors both in this country and in the United Kingdom can practice good medicine for their patients.

Mr. **Levin**. Well, I was going to ask you about that. And my questions really are an effort to push you a little to prioritize without being categorical.

Because I think the Congress and the administration, whoever is going to run it next time, are going to have to have some hunches as to what baskets we put our eggs in, not that we would do so, just one or the other.

But there has to be some sense of priorities, right?

Dr. **Roper**. Oh, sure.

Mr. **Levin**. And where would you rate this? Is this one of the avenues that you would emphasize?

Dr. **Roper**. This is one of the areas that I would especially emphasize, because I think it yields results for the better practice of medicine, and therefore, good things for patients. It has the potential of protecting doctors more against malpractice, and therefore good things for doctors.

And it may, over the long term, help us spend our money better. So it is a win-win-win situation.

Mr. **Levin**. Right. Now there are various ways to do it. You mention on page 16 that standard of practice is ill defined or based on weak evidence. So what are you suggesting somewhat more concretely?

Dr. **Roper**. Sure. There are several experts who are recommending slightly different things in this area, but the basic idea is that we would convene the Nation's experts and try to focus attention on items of particular importance to the Medicare program; for example, those items that are done most frequently, or those on which there is most dispute about the appropriate practice, or those that have the greatest dollar impact for us under the program.

If, after convening these expert panels, we are not able to come up with fully—a full state of consensus on practice, then the next level would be using our data set. We have the world's largest information set on medical practice, the Medicare administrative data set which can be used to do studies where you compare various kinds of interventions; for example, medical versus surgical therapy for heart disease. We can and are doing that in-house right now.

We would like that to be done on a much wider basis by the wider research community. Ultimately, it probably will mean funding several controlled clinical trials, where you select a cohort of patients, and observe one therapy in one group versus an alternative therapy in another group.

What I am describing for you is a continuous process over many years of time to develop information on what works in the practice of medicine.

Mr. LEVIN. In order to make that work, if you have standards, you have to have some mechanism for enforcing them, right?

Dr. ROPER. Well, I think the first and most important basis for the enforcement of standards is the professionalism of America's doctors, because I think they want this kind of knowledge.

Mr. LEVIN. You would rely on that entirely?

Dr. ROPER. I think ultimately the people who pay for services will want to look carefully at the information. It might have some impact on the payment system.

But I do not want to lead with that. Because I do not think this is a cost-restraining exercise so much as it is a quality improvement exercise. If I could just add one further point. My wife is Deputy Director of the National Cancer Institute, and they invest heavily in research to come up with the latest, greatest treatment. And I am happy for that.

To compare, though, the budget that we and the National Center for Health Services Research have, in comparing today's treatment and tomorrow' breakthrough, is minuscule compared to what the NIH has.

And I, again, am making a plea for our publicly investing much more into health services research.

Mr. LEVIN. I think my 5 minutes are up, and I know we have other witnesses. I guess, Mr. Chairman, this is just the beginning, is it not?

Chairman STARK. It is a broad beginning. And I do not know what to ask Dr. Roper except that I do not think any of the committee members or staff have come up with anything that would disagree and/or answer the conundrums that you pose.

Let us accept for a minute that we do decide, or the Nation pushes us to decide, that we do want to limit the overall costs of physician care. My inclination is to say that is what the Congress ought to limit itself to in the sense of the aggregate or the global amount, because we can deal in a macrosense with inflation and comparative averages and medians. And as it is said so often, we ought to decide the size of the pot, and let HCFA or the proper professional groups decide how to carve the pie up.

At some point, I think that is the second decision we have to make. I guess what I am saying is, if we decide we are going to limit the amount, how much further is it our responsibility as legislators to go on than to just say, OK, this is where the pie is going to be? Or do we then follow the suggestion Mr. Gradison had earlier or the Canadian system? But we say, that by whatever way we can devise, we are not going to see the total costs increase more than 10 percent next year.

Now, is that too irresponsible? Does that throw the system into disarray? Or can a responsible bureaucracy, both Government bureaucracy and subspecialty, professional bureaucracy, take that and accommodate access and quality within it?

Dr. **Roper**. You asked the $64 question. Can it be made to work? I think it can be made to work. It will be difficult, controversial, perplexing at times; all of the things that you have dealt with the last several years of hospital payment, but multiplied by a hundred times.

Let me try to draw an analogy for you. In my testimony I said that one of the things we need to be doing more of right now is utilization review. That is the latest buzzword. Everybody is excited about utilization review. Last week's New England Journal of Medicine has an article about "Private Cost Containment: The Effects of Utilization Review Programs."

And they say utilization review works. You spend money; you save money.

The problem with utilization review, from a political standpoint is that what utilization review does is say no. It is saying that under this circumstance, we will not pay for that service. We do it either ahead of time, and the patient does not get admitted or does not get the service, or we say it afterward, and somebody is out the bucks because we do not pay for it.

And that all generates controversy and political heat. And as I have tried to say before this committee and others, the things that are involved in setting limits and saying no and whatever else are surely going to be highly controversial. That is not a reason to shrink from them, but I just want us all to be fully informed in this matter.

I think setting limits is something that we need to have a debate about; that is my central point.

If I could just touch briefly on the Canadian question. I am anxious to learn more about what they are doing in Canada as well.

But I would point out that the United States is a more diverse Nation than is Canada. Layered on that is the very subjectivity of the practice of medicine, and the problems that brings to this issue.

And that is why I continue to argue for a decentralized decisionmaking process, the private health plan idea. A minute ago you were saying that the Congress should set how much to pay in the aggregate; that is what I am for.

How much per beneficiary in the aggregate? Pay that to a private plan and let them operate it.

Let me just finish my point. The other thing I would say about Canada is, as you especially understand, we have significantly different political systems here and in Canada. They have a parliamentary system of government. The party in power decides. The cabinet decides. And the members vote with the party, and boom, it happens.

Things do not happen quite that way in this country.

Mr. **Levin**. Not quite.

Dr. **Roper**. And I do not think we ought to lose sight of that in embracing readily the Canadian system.

Mr. **Gradison**. One of the ironies to me of the Canadian experience is that their system of health care is far more decentralized than ours, at least with regard to the elderly. We have insisted on a uniform national plan. They do it with the elderly, and we are talking about adding to it with catastrophic health insurance, and I am sure later in long-term care, in a direction which is uniform.

They have a different system for each province. And if somebody got up here and suggested that we should have 50 different systems of health care for the elderly, perhaps with some kind of Federal stimulus, they would be considered Neanderthal.

So I think it is an interesting counterpart. They have outdone our federalism, and we have outdone their centralization.

Chairman **Stark**. And they are more conservative than we are.

Thank you. I guess one of the few sadnesses that I see at having a change in the administration, whatever it may be, is the opportunity to deal with you and Dr. Bowen on these matters next year.

Dr. **Roper**. I have not resigned yet. [Laughter.]

Chairman **Stark**. But I am sure you will be welcomed back in whatever role you assume in private life. [Laughter.]

Dr. **Roper**. Thank you.

Chairman **Stark**. Thank you very much. I would like to suggest that it will be the Chair's intention to work through lunch.

We will be interrupted, I am sure, by some votes around noon. If the members will cooperate with the Chair, and run and vote and come back as quickly as they can, then we will continue on with the hearing.

Also, we will welcome any witnesses who care to speak with their mouths full. So those of you who are on the witness list, if you would like to break for lunch, we will try and accommodate you.

And members, I hope, will try and grab something to eat between votes, and we can continue the hearings.

Again, Dr. Roper, thank you very much. The next witness is Phil Lee. Dr. Lee is the Chairman of the Physician Payment Review Commission, which has become known for better or for worse as PPRC. We welcome you to the committee.

And Dr. Ginsburg, who is the Executive Director of the PPRC, I do not know whether you have testimony to present or whether you are just here to keep Dr. Lee honest; but whichever function it is I am sure Dr. Ginsburg performs honestly. Proceed in any manner you are comfortable, and we look forward to your testimony.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. **Lee**. Thank you, Mr. Chairman.

I would like to briefly review with you the testimony which we have submitted for the record.

Chairman **Stark**. Without objection, that will appear in its entirety.

Dr. **Lee**. I will make a couple of comments on what has been said to date. First with respect to goals, I think the Commission would certainly strongly agree with your statement about the goals of access and the program's costs being affordable to the taxpayer, and certainly to the beneficiary, because we have seen increasing costs shifted to the beneficiary.

It seems to me that a third goal is one that is implicit in most of our public policies in the United States; that is a goal which I would call freedom.

We have in the Medicare program, a freedom of choice for beneficiaries. We would like to maintain that freedom of choice.

Perhaps in the report we should have placed the volume utilization, and cost chapter first, rather than the chapter on the relative value scale. I say this because we would agree with Dr. Roper that the volume issue, the intensity of service issue, is even more important than the issue of what kind of a fee schedule the Congress ultimately adopts for the Medicare program.

Congressman Levin discussed the report's complexity. The fact is that the report is 320 pages long, and we make very few specific recommendations in that 320 pages. It does discuss the complexity of the issues we are dealing with.

The report has four parts. First, the report presents progress on the development of a fee schedule; second, the section on utilization, costs and quality; third is capitation; and fourth is data.

In our 1987 report to Congress we recommended a fee schedule to replace the existing method of paying physicians based on customary, prevailing and reasonable charges.

This past year we have moved beyond that. We are now looking more definitively at the benefits of a resource-based relative value scale as opposed to a relative value scale based on historical charges.

In a resource-based relative value scale the important components, are the physician's time and effort, skill, the stress involved, and then the cost of practice, what some would call the overhead costs—rent, staff salaries, malpractice insurance premiums, and the like.

We believe that a relative value scale based on resource costs would promote a more efficient and more appropriate allocation of medical services, and we think it would be more equitable among physicians.

The primary goal, however, is to improve the efficiency of the system. We do not believe, however, that a relative value scale should stand alone. We will submit our report next year with recommendations with respect to utilization, volume, and cost and quality, as well as with respect to assignment and participation.

During the coming year, as soon as the Hsiao report is received, we will be analyzing it. We have been working with Dr. Hsiao and been informed of the progress of that study on a continuing basis.

We will look at the assumptions and the methods used by Dr. Hsiao and his colleagues. We will then do simulations of the effects on physicians and beneficiaries. I think that is going to be a very useful approach. We will of course provide the Congress with detailed simulations, and we will also provide them to the various professional groups and the beneficiaries.

What will be the impact on primary care physicians? What will be the impact on the old old? What will be the impact in different geographical areas? We will attempt in those simulations to come up with that information, somewhat along the lines of the material that Dr. Roper mentioned in his testimony.

We will conduct public hearings to solicit reactions of consumer groups, of the medical profession, the various specialty groups and other interested parties. We will also have physician panels that will be reviewing the recommendations. They will particularly be asked to extrapolate from the limited number of procedures that Hsiao has studied, to the whole range of procedures performed by physicians, so that we will have an estimate of the impact for the whole range of services, not just for a limited number of services.

Another area that is very important is geographic variation. Following the Commission's principle that payment levels should be tied to resource costs, we are working on a cost-of-practice index to guide geographic adjustments and fees. We are also searching for factors that are not adequately captured by such an index, for example, special circumstances in rural areas.

Specialty differentials is another issue. There is no national policy with respect to the definition of specialists, even by different carriers. And there are a number of issues with respect to specialty differentials: Regarding procedure coding, we are looking at global surgical services and office visits. We will also examine some of the issues around the possibility of some clustering for some office-based services and hospital services for the nonsurgeons, in other words, for the internists or family practitioner.

Assignment and participation are issues of great interest. We deal with these issues in two chapters, chapters 9 and 10 in our report. Significant progress has been made, Mr. Chairman, as you pointed out, and as Dr. Roper pointed out in his testimony.

We did not make specific recommendations about assignment and participation in the report, but we detailed the various policy options, including those we will be considering. With respect to a cost-based relative value scale, I do not see a disposition on the part of the Commission to have mandatory assignment when we issue our report next March. We want to see if there are ways to further improve the assignment rate, but I do not see the Commission recommending a Massachusetts-type restriction.

We also deal in the report with payments for diagnostic services with a substantial nonphysician component (chapter 11). Because these services are similar in many ways to those performed in the clinical laboratory, we want to look more closely at the experiences with the fee schedule that has been established for clinical laboratories; the policies that Congress has established and HCFA has implemented.

Then the report addresses utilization of services in chapters 12 to 14. Again we look at the possible approaches to that: utilization review; practice guidelines; feedback to physicians; expenditure targets. And you have certainly discussed that some in this hearing already.

A key question about this kind of approach is how would individual physicians respond; how would the medical community support and encourage a constructive response to an expenditure target; and whether there should be part B expenditure targets, or Medicare expenditure targets, or whether, as they are in Canada for example, expenditure targets should be across the board.

One of the key factors in Canada is that there is a single payor. Here we have multiple payors. And I think in looking at this, this committee needs to look more broadly, beyond Medicare, to the private sector as well.

And we certainly are, as a Commission, going to reach out to the business community, to the insurance community, to the other purchasers in the private sector, to look at the policy options that we will be developing for our next report to encourage active consideration of these policies by private third parties, and to see if we cannot encourage a much broader approach rather than simply a Medicare fee schedule. The more the private sector adopts that, the greater the benefit I think there will be for the elderly beneficiary not being treated differently than others.

On capitation, we continue to be very supportive. We do raise some issues with respect to quality in HMOs. In the 1988 report, we recommend that all HMOs participating in Medicare risk contracts be subject to an accreditation process that assesses each organization's structures for quality assurance and the arrangements for compensating physicians.

With an expenditure target for example, there needs to be some mechanism for this kind of structural systems approach to the problem. I think the chairman was really getting at this with his remarks. If the Congress sets the national policy, we have got to find ways to implement it at the local level. This could be through the county medical society or through its other mechanisms for dealing with utilization, rather than having an overly intrusive system of utilization review from the Federal Government.

We also deal with payments to HMOs and there are some problems there that we describe.

And finally, in chapter 17, we deal with an area that tends to be underemphasized; and that is Medicare data. The chapter describes the importance of Medicare data and the need to develop a strategy for its development.

I would certainly strongly support Dr. Roper's comments with respect to a very large increase in funding for health services research, both in the Health Care Financing Administration, and in the National Center for Health Services Research, in order to provide policymakers with the necessary information to make sound decisions. In many of these areas, you are operating, as we are, relatively in the dark.

That will conclude my comments, Mr. Chairman, and Dr. Ginsburg and I will be pleased to answer any questions on the report.

[The prepared statement follows:]

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman and Members of the Committee, I appreciate the opportunity to come before you once again to report on the work of the Physician Payment Review Commission. A year ago we discussed our endorsement of a fee schedule for Medicare and outlined a corresponding agenda of analysis, consultation, and policy development. Since then we have appeared here to discuss overvalued procedures and escalating Part B costs with particular emphasis on the problem of increases in the volume of service. The Commission's 1988 report builds on the ideas previously discussed with you but also breaks new ground analytically and conceptually.

This testimony briefly reviews the reasons behind the Commission's original endorsement of a fee schedule to replace Medicare's current method of paying physicians. It then describes how the Commission is approaching key questions about the design of such a schedule. These include the basis for establishing relative payment levels for different services, the treatment of geographic and specialty differences, the definition and coding of physician services, and the role of balance or extra billing of beneficiaries when charges exceed Medicare allowed payments.

As very clearly highlighted in your September hearing, recent increases in outlays and beneficiary premiums have been fueled more by increases in the volume of services than by increases in prices. Our 1988 report examines in some detail the need to integrate changes in the method of payment with policies to encourage more appropriate use of physician services. Each of the report's three chapters on strategies to control volume emphasizes that we have much to learn about limiting the provision of unnecessary services without discouraging the provision of needed care. The entire report stresses that the impact of policies on beneficiary access to quality care is an overriding concern in all the Commission's work.

The Commission's expectations for its reform package are optimistic but tempered by a recognition that these reforms will not singlehandedly limit Part B costs. The pressure for higher spending on health care comes from powerful technological, legal, and economic forces that will not be easily reshaped or contained. We discuss some of these forces in the conclusion to this testimony.

A FEE SCHEDULE FOR MEDICARE

In its 1987 report to Congress, the Physician Payment Review Commission endorsed a fee schedule for Medicare to replace the existing method of paying physicians based on customary, prevailing, and reasonable charges (CPR). The result of years of CPR is a distorted pattern of Medicare payments for different medical services. This, in turn, has created undesirable incentives for physician decisions about what services to provide, where to practice, and how to specialize. The current system is also inordinately complex and difficult to manage.

Relative Payment Levels. During the past year, the Commission has made considerable progress in designing a fee schedule that would correct many of the deficiencies in the existing payment system. In particular, it has defined the conceptual basis for setting relative payments for different physician services. This component of the fee schedule, commonly termed a relative value scale (RVS), should be based primarily on the resource costs of providing services. These costs include physicians' own time and effort and their costs of practice, for example, rent, staff salaries, and malpractice insurance premiums. The only practical near-term alternative to a scale based on resource costs is one based on physician charges. Such a scale would largely incorporate the distorted incentives that created the demand for payment reform in the first place.

A relative value scale based on resource costs would promote a more appropriate and efficient allocation of medical services and should generally be seen by physicians as more equitable. Today, a physician can make several times more per hour doing endoscopies than evaluating patient problems and developing treatment programs. Payments for procedural services such as pacemaker insertion and cataract surgery that are excessive in relation to their resource costs may lead to overuse of these services. The financial promises made in advertisements for much diagnostic testing equipment suggest that these services may be overpriced as well. The results of overpricing are increased outlays without comparable improvements in care.

During the past year, the Commission has compared Medicare relative values for selected services with those developed by other payers through negotiation, assessments of resource costs, or other noncharge-based methods. The results of these analyses have helped guide legislation to reduce payments for overvalued procedures, an interim step consistent with our recommendations for long-term reform.

Designing a sound, comprehensive RVS based on resource costs presents several technical problems. Many of these problems and some possible solutions are illuminated in a Congressionally mandated project being undertaken at Harvard University by Dr. William Hsiao and his colleagues. This summer Dr. Hsiao will report on research to design an RVS for services and procedures in 18 specialties. The Commission will analyze carefully the project's assumptions and methods, simulate its effects on physicians and beneficiaries, and conduct public hearings to solicit the reactions of medical, consumer, and other interested groups. It will also examine related research and consider the approaches taken by other payers in this country and elsewhere. If the Commission finds inadequacies in the work done to date, it may sponsor further surveys and convene consensus panels to propose refinements.

Geographic Variation. In addition to setting relative payments for different types of physician services, a fee schedule must specify how payments will vary by geographic area. The Commission's analyses indicate that geographic variation, although not trivial, is less extreme than generally believed. Differences in physician costs of practice, although important, explain less of this variation than might be expected. Following the Commission's principle that payment levels should be tied to resource costs, staff are working on a cost-of-practice index to guide geographic adjustments in fees. We are also searching for factors that may not be adequately captured by such an index, for example, the special circumstances of rural areas.

Specialty Differentials. The Commission has started to define a uniform national policy for specialty differentials. Again, the basic principle is that payment differences should reflect differences in resource costs rather than differences in specialty designation. Many services are provided only by one or a few types of specialists, and resource-based payments for those procedure and service codes should capture the value of specialists' work. Office and other visits are an exception to this pattern and may need to be paid differently for different specialists or coded differently to better reflect systematic variations in the content of visits.

Procedure Coding. In general, a fee schedule will require considerable standardization in the use of codes for physicians' services. The HCFA Common Procedure Coding System mandated by Congress has overcome some problems stemming from variation in the ways services are defined and coded by physicians and Part B carriers. However, much ambiguity, variability, and misuse remains.

Two priorities for the Commission's work on coding are global surgical services and visit services. We will convene an interspecialty consensus panel to develop a generic description of surgical global services. Physician experts will then identify the components of specific surgical procedures.

Coding of visit services is a particularly thorny issue. To understand the problem more fully, the Commission plans to survey physicians to determine how they interpret the differences in current codes. It will consider whether alternative definitions or other approaches might increase uniformity and specificity in the use of codes.

Assignment and Participation. Congress has done much to encourage physicians to accept Medicare allowed charges as payment in full. Physicians currently accept assignment for nearly three-quarters of Medicare claims. Still, beneficiaries paid over $2.5 billion in 1987 for balance billing on nonassigned claims. The Commission is sensitive to beneficiary liability for extra billing but is also aware of the importance to physicians of Medicare's traditional policy that lets physicians choose whether or not to accept assignment.

The Commission has not yet made recommendations on assignment, but our March report has developed much of the background for future decisionmaking. The major dimensions of policy on assignment are: Should policy cover all services and beneficiaries or focus selectively? Should extra billing be eliminated or, as now, limited in some way? What relative balance should be sought between policies to encourage assignment versus policies to prohibit or limit balance billing?

UTILIZATION OF SERVICES

Although a fee schedule is likely to encourage more appropriate choices among diagnostic and treatment options, it generally retains the incentives for overutilization that plague fee-for-service payment methods. The Commission is considering both shorter and longer term strategies to deal with the volume problem. On both fronts, strategies should selectively reduce services of least benefit without threatening the many valuable services for which Medicare pays.

Success in controlling volume will require the following. First, Medicare beneficiaries and their physicians must be willing to forego services of little or no benefit. Second, all parties--physicians, beneficiaries, and others who influence medical choices--must have more usable and complete information about the effectiveness of alternative medical services. Third, there must be incentives to use such information to eliminate unnecessary or minimally beneficial care.

Utilization Review. The Commission believes that utilization review in Medicare can become more effective in controlling volume and more credible within the physician community. This will require more systematic evaluation of the clinical soundness of existing review efforts, more careful assessment of the impact of different methods for review, and more research to focus program efforts and physician responses on real utilization problems. Several private organizations are doing sophisticated work to increase the efficiency and quality of utilization management. Medicare policy makers should consider how it might use this work--either directly or as a guide to innovation and refinement in PRO and carrier review activities.

Practice Guidelines and Feedback. Because utilization review is a relatively costly, intrusive, and limited tool, additional strategies are needed to improve physician knowledge and application of effective and efficient styles of practice. The Commission is particularly interested in two approaches: practice guidelines for specific services and feedback to physicians of information on how their practice patterns compare to others'.

Our knowledge of what treatments work for what patients is incomplete, and much more controlled clinical research on the outcomes of new and existing treatments is needed. Even so, the knowledge we already have could be better used by physicians and patients. Both feedback and practice guidelines can help bring scientific knowledge more fully to bear on the day-to-day practice of medicine. The Commission will be soliciting the advice of the medical community and others on what might be the priorities, funding, processes, and structure of a strategy for such knowledge development and transfer.

Expenditure Targets. The Commission is also investigating a more global approach to the volume problem, that is, expenditure targets. The idea would be to adjust updates in physician fees up or down on the basis of how total expenditures match a predetermined target. If physicians could collectively control the volume of services, they could achieve a full scheduled increase in fees (or more) and free themselves from some intrusive regulation. Key questions about this kind of approach are how would individual physicians respond and how could the medical community support and encourage a constructive response. The feasibility of such an approach also depends on a variety of technical and policy factors including the quality and timeliness of expenditure data, the variables to use in projecting trends and setting targets, the effectiveness of quality assurance techniques, and the mechanisms for tying global targets to payment administration. These issues are on the Commission's agenda for the coming year.

CAPITATION

In addition to reform in fee-for-service payment, the Commission wants to improve Medicare's use of capitated payment. Capitated programs are attractive for their potential to contain costs and increase access for some beneficiaries.

Quality in HMOs. The Commission is concerned about quality of care in fee-for-service medicine and will have more to say on that subject in the coming year. Its initial focus on capitated systems arises from special features of these systems. Specifically, beneficiaries are "locked in" to the system's panel of providers, and these providers generally operate under payment incentives to provide less care. The Commission's 1988 report recommends that all HMOs participating in Medicare risk contracts be subject to an accreditation process that assesses each organization's structures for quality assurance and its arrangements for compensating physicians. Participating HMOs should also be required to give physicians detailed explanations of financial arrangements and to inform beneficiaries about organizational features that could positively or negatively affect the care they get.

Payment to HMOs. The current method of paying HMOs under Medicare needs a better adjustment for differences in the health status of enrollees. Now HMOs may be penalized for enrolling sicker beneficiaries and may be inappropriately rewarded if they attract healthier individuals. One health status adjustment, the diagnostic cost group, is close to being operational, and the Commission recommends that it be incorporated into the capitation formula soon.

Evidence also exists that unwarranted geographic differences in capitation payments may discourage HMO development and success in some areas of the country. Low payment levels may indicate underservice and access problems that HMOs could help remedy. The Commission has proposed a floor on county-specific payments and is working on associated technical issues.

MEDICARE DATA AND ADMINISTRATION

Successful reform of physician payment and improvements in program management depend on changes in Medicare data systems. The Commission has outlined a thorough process to define data needs, propose feasible strategies for data collection, and plan for implementation in conjunction with the fee schedule.

In both its 1987 and 1988 reports, the Commission has repeatedly touched on the administrative problems faced by HCFA, Part B carriers, PROs, and the physicians and beneficiaries with whom these organizations deal. Over the years, a complex physician payment system has had layers of additional complexity grafted onto it. Some changes represent attempts to correct intrinsic deficiencies in CPR, others are attempts to cope with larger system problems. The Commission believes that policy change should be sensitive to administrative feasibility, including the reasonableness of timetables for implementing changes, the potential for management overload and resulting deficiencies in program oversight, and the need to consider the administrative costs of new policies. As part of its proposals for reform, the Commission will consider how a transition from CPR to a fee schedule should be designed, implemented, and monitored.

CONCLUSION

The Commission believes that the steps outlined in its 1988 report to Congress, many of which I have summarized in this statement, can help control the rate of increase in Medicare outlays for physician services. However, we must stress that quick and simple solutions to the problem of rising costs do not exist. Significant progress will require a variety of responses that are developed and pursued over a sustained period.

Without underrating the potential for positive change, we must be sensitive to the important limitations on what Medicare payment policy can accomplish. For example, Medicare generally is not as big a factor in physician income as it is in hospital income, although some specialties do depend heavily on revenues from the program. This may limit the magnitude of change that Medicare can achieve, particularly if private payers--insurers and large private employers--do not alter their payment schedules.

Other factors are outside the reach of payment methodology altogether. For one, continued increases in the supply of physicians will be a powerful force towards additional services, even if greater competition depresses fees. And the success of direct attempts to control the volume of services will depend, in part, on the attitude of the general public towards foregoing medical procedures of uncertain benefit. In addition, fears of malpractice suits may dampen physician interest in economizing on the use of services. For these reasons and more, a comprehensive approach to containing costs must go beyond reform in the way Medicare pays physicians.

Chairman Stark. Thank you very much, Dr. Lee.

Mr. Gradison, would you like to inquire?

Mr. Gradison. Thank you, Mr. Chairman.

Dr. Lee, as you know, with your help we did legislate last year with regard to a list of so-called overpriced procedures, a short list, based on the data you had available.

In doing so, it was my understanding of the methodology that what you were basically trying to do was to bring our payment schedule for these procedures in line with what is being done by certain large private payors, some of the insurance companies and others, where we might have been out of line.

My question relates to something which you mentioned, and clearly, I think, will be very critical to the success or failure of a change in the Medicare payment system. And that is, do you have any sense as to whether the private sector is watching with more than academic curiosity what Dr. Hsiao is doing and what you are doing with regard to a resource-based relative value scale?

Do you have any sense as to whether, if we move in that direction, it will be widely followed by other larger payors?

Dr. Lee. Well, I would say that in some conversations we have had with people in Blue Cross/Blue Shield, particularly, there is very definitely an interest in this. It was interesting that when Medicare adopted the policies in 1965 or 1966, when it was implemented, many of the private payors adopted those same policies for paying physicians.

But I think without involvement of the private sector, business, the insurance carriers, and the consumer groups who are purchasers, we will not achieve the kind of involvement of the private sector in the modification of current physician payment policies, so that they are more consistent across public and private sectors. I would also hope, although at the moment it is not one that I feel optimistic about in the short term, that Medicaid would adopt the same policies.

We should not have the kind of gross underpayment of physicians that we have in most Medicaid programs, because it really is denying the poor access to care. That was not the intent of Congress when that program was established. So I think we need to also involve the States, and the State Medicaid programs, as well as legislatures and Governors' offices, as we move forward toward the development of a resource-based relative value recommendation for the Congress next March.

Mr. Gradison. That is extremely helpful. I watched, as I am sure many of us have, the development of coalitions mainly of business purchasers in various communities, and I wondered some times whether we could adapt the same approach for the development of a national strategy for trying to restrain costs.

Obviously, no private group has to participate with us, but it may be that some of these large payors would welcome the opportunity as we are trying to put together, let us say, a change in physician reimbursement to sit down with us and to think the thing through.

And if they think it through with us and see some merit, they may be more willing to adopt it themselves independently in their own role as large purchasers of health care.

That as you point out could well include, and probably should include, people from State government, as well as what we normally think of as the private sector, which is largely business purchasers.

Dr. **Lee**. We, for example, are intending to contact John Dunlop at Harvard, who has this group of six that he works with. The American Hospital Association has a regular contact with 150 business groups on health. We intend to work with them to reach out to those groups.

So we are intending to make an aggressive effort to reach out, not only in form, but involve them in the process, that we will be going through. We have involved mainly physician groups and groups representing the elderly to date.

We now see the necessity for involving these other groups in the process.

Mr. **Gradison**. Thank you. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Welcome back. Let me just cite some testimony that is coming and ask you to briefly comment on it.

This is from the testimony of the American College of Surgeons on page 4. And I know this is already kind of an old argument, but just if you would, give us your rejoinder.

It says: "Thus the college takes the position that there is much yet to be done in evaluating use of an RVS as a basis for evaluating a Medicare fee schedule. We believe defining and measuring value are problematic, raising the need for consideration of alternative ways to establish a fee schedule."

Specifically, we believe that actual physician charges also need to be examined and compared with alternative evaluation methods in any effort to create a Medicare fee schedule.

Dr. **Lee**. The process that we will go through in evaluating the Hsiao study that is, of course, a resource-based approach, will be one that is a very open process, in terms of public hearings and physician panels participating, to determine before we make recommendations next year to the Congress if, in fact, that is the best approach.

We do not have enough facts yet to say that categorically. It is the Commission's view, with three dissenting opinions, that using a resource cost basis for determining relative values is the best approach, and the one that we should use as the conceptual basis for our analysis.

I believe that it will prove to be a sound approach. But we are still not closed minded. Certainly, we have great respect for the surgeons. We have had, as a member of the Commission, Dr. Oliver Beahrs, who is one of the leading surgeons in America, and a former chairman of the board of regents of the college. He soon becomes president of the college. He is leaving the Commission, but being replaced by an equally articulate surgeon, Dr. William Carreri. We will be very open to the surgeons and others' views about this issue. And I think that is where we stand as a Commission.

We clearly do not agree with the current position of the College of Surgeons, but we respect their views, and will certainly be taking them into consideration as we go through the process and before we make recommendations to you next March.

Mr. LEVIN. Do you think that we can avoid an automatic choosing up of sides on this issue of physician charges and costs, as we've tended to see in the debate over medical issues in this country?

You could predict invariably where people would be depending on their particular profession or their particular position. I will not call it interest, because that tends to be pejorative.

But this whole issue of health care has been so beset, as we know, by kind of reflexive, I think, automatic choosing up of sides. Do you think we can avoid it as we face this issue of how to get a handle on Medicare physician charges?

Dr. LEE. Well, of course there are, within the medical profession, a range of views, just as there are in society. We do not have a homogeneous profession. While on certain basic issues, the profession is coming close to agreement, I do not think that agreement has been reached yet by any means. When you come to the pocketbook issues. you are most likely to see divisions.

I think the Commission is cognizant of that. One of the things that Congressman Gradison mentioned earlier was the transition; that is, if you go from the current system of payment to a new payment system, what are you going to do about a transition period? I see, at a minimum, a 4-year transition. The geographic multipliers are a further complication, because some areas have payments that are considerably higher than in other areas. In order not to adversely affect access, we have to be very cognizant of geographic differentials when making recommendations to the Congress.

I think in some of this there is an almost inevitable difference of view. But that does not need to mean a split, in the medical profession on the basic objectives of the program, the efficiency objectives, the equity objectives, or the freedom objectives, which are broad objectives, although some groups will say, well, you are reducing our fees too much, as the opthalmologists did on the overvalued procedures. Yet you talk to many other physicians and they say, you made very sound recommendations.

You cannot make them all happy, that is for sure, because we are in a constrained environment economically. Every country, every Western European country, every industrialized country, is constrained in terms of resources it can devote to health care.

The United States devotes more money on a per capita basis and as a percent of GNP than any other country in the world. So that other countries would say, they would be glad to take—for the professions in those countries—what we allocate.

So I do not think it is so much the total. It is that we do have these serious distortions in the system. And that is why we have to deal with both the fee schedule, and we then have to agree on some way to deal with the volume/intensity issue that is realistic and appropriate in terms of physicians and beneficiaries.

Mr. LEVIN. Thank you.

Chairman STARK. Phil, I find that your testimony almost presumes that I got a different answer from Dr. Roper. In other words, if we had agreed that that we were going to limit the aggregate dollars—which really deals with the concern of the elderly and the taxpayers—what you have outlined deals with taking care of the physicians, who are, arguably, the most well-taken care of people, from an income standpoint, in the country today.

I guess what I want to push you to tell us is how are we going to control volume? You and Dr. Roper seem to be at opposite ends. Are you saying the relative value scale may control volume?

Dr. **Lee**. No, no. I do not say that at all. No, absolutely not.

Chairman **Stark**. All right.

Dr. **Lee**. I think that it will make a contribution to controlling volume by removing some of the distortions that now exist, but the Commission does not believe that it will be the answer to the volume/intensity question. Any time you have a fee-for-service system, volume is going to be a problem.

Chairman **Stark**. If we said to you, to PhysPRC, take whatever we are going to end up with in calendar year 1988—and design for us a plan for 1990—we will spot you double inflation—let's just say 8 percent a year could—you then take that and come back to us and say here is how we ought to divvy that up?

And again, you may force us to that. If you say we cannot control the volume, then, the political realities are that it is very difficult for us to say no.

But the simplest way is to take the aggregate, and maybe a fee freeze, and then come back to you.

What do you do then? Where do you go? Can you do it with a fee schedule alone?

Dr. **Lee**. Well, I would say that we would. I will speak from the standpoint of the Commission and then make a personal comment about expenditure target idea.

Let's say double the rate of inflation. First of all, as the Commission, if you requested us to analyze the impact of an expenditure control that increased at double the rate of inflation, we could analyze what the consequences of that might be, with the current system of payment. Furthermore, although it would be less easy to do, I would certainly consult with Paul and get his views about whether we could feasibly develop some simulations that would give estimates of shifting over, let's say, a 4-year period to a relative value scale based on costs.

I personally am attracted to the idea of an expenditure target because I think that it is appropriate for Congress to set policy and not to try to fine-tune the system.

I think it is the responsibility of the medical profession to control inappropriate utilization. It is very clear, even though Dr. Roper was surprised at the extent of the Chassin studies and the other RAND studies, and UCLA studies, about what appears to be the extent of inappropriate utilization of services. I think there are others who generally agree with that, so we have got a very serious problem.

Inappropriate utilization is a problem for the medical profession. If it does not deal with that problem, then the Congress is going to have to fine-tune and increase utilization review, increase all these kind of external controls.

But I think if you can set some external controls, which you could do with an expenditure cap, the internal controls can be effected by the medical profession.

I do not think there are many people who would say that if you went to the Mayo Clinic you did not get quality medical care. There is an institutional mechanism for assuring quality. I believe we have many other mechanisms that can be used for doing that.

One of them is—and I do not say that the commission has been very enthusiastic about this up to now—the preferred provider organization.

That is another alternative for physicians to examine much, much more openly. County medical societies may be another vehicle. I think that the fine-tuning, the internal controls are the responsibility of the medical profession. I am sad to say, but it is interesting—in every other country where there is expenditure control, physicians have far more professional freedom, clinical freedom, than they do in the United States.

Despite the resource constraints in the United Kingdom, they spend one-third as much on a per capita basis as we do on medical care. We spend more on Medicare and Medicaid than they do on their entire national health service: Yet if you ask any physician, consultant or GP, whether they would trade their clinical freedom for the restrictions that are placed on physicians in the United States, very few would trade.

Or the French or the Germans or the Canadian physicians. They have much more clinical autonomy. And I believe that is appropriate. So I am very attracted to this idea.

Chairman **Stark**. I assume that in your idea on the private market you do not mean individual patients shopping, but rather sophisticated purchasers of the service.

Dr. **Lee**. Absolutely.

Chairman **Stark**. I think it might be interesting—and I think my colleague, Mr. Gradison, has hinted at this—if Joe Califano ends up being able to do, working for Chrysler, what he could not do working for Jimmy Carter, because he has no political pressures to succumb to.

Joe Califano can go in and say look, guys, this is what we will pay you. Do you want our business? Then we come in behind him and say, hey, if it is good enough for Chrysler it ought to be good enough for the U.S. Government.

It may be poetic justice, in the end, that he does not have to succumb to political pressures and that may set the way for the Goverment.

Dr. **Lee**. Chrysler, General Motors, General Electric, Caterpillar Tractor, and all the major U.S. companies that are competing in the world markets have got to find some way to control medical care costs.

It is their most rapidly increasing expense, and it is the one that is still out of control.

Chairman **Stark**. We may look pretty good to the AMA before long. [Laughter.]

Mr. **Gradison**. Mr. Chairman.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Well, I have been uncertain whether the right answer is to have some national plan. I mean in certain respects, in my own mind, I have been wondering about what I would call most-favored nation's treatment, to use the trade analogy, which is to say in any given community we are not going to pay any more than anybody else pays.

And so you go in and you look and you see—what does General Motors pay, what do the Blues pay, what do the commercials pay—and you say that is our price, guys. We did not set the price. It was set by a PPO, it was set by an HMO, in their negotiation of a contract with the hospital or the physician, and we are not therefore leading, we are following, which I think takes away some of the political sting to this.

I am not sure if that is practical, but I have been intrigued by the willingness of HCFA to experiment with the PPO concept, which is not dissimilar from what I am talking about, because there, they are not talking about developing a new PPO.

What they are talking about is going into a community with Medicare dollars and using the PPOs which are already in existence.

And if it is possible to make that work for physicians, I cannot see why it would not work for hospitals, too.

Dr. LEE. On decentralization, it seems to me that if you have a national relative value scale, which the private sector, as well as Medicare and Medicaid accept, then as Medicare goes into the community it would be in a much stronger position than with the present system, which lets each individual doctor set fees.

Chairman STARK. The other thing I would just like to comment on is the idea—I think you mentioned in your testimony—of certifying HMOs?

Dr. LEE. Yes.

Chairman STARK. My test has always been—and I am sure Dr. Roper would say that it is not possible, but I bet you it is—that I could start an HMO.

Dr. LEE. You and I start one.

Chairman STARK. I could start an HMO by just going out and renting an Apple computer, and a big revival tent, and doing whatever I had to do to get enough seniors in there. The HMO system is potentially in trouble, and I make that judgment by what I think the opportunities for chicanery are, not by suggesting professional incompetence. I am talking about business types who get into promoting and selling subscriptions, and make Tupperware and Amway look ethical. I think that is a real problem that they have yet to address.

There is not enough tradition in the HMO industry. And nobody's really ever accused a nonprofit hospital about hustling. I mean, they are not stealing money.

But there are no rules. There is no law that says you'll maintain this percentage of your capital to your assets, or you'll have these kind of reserves to pay your bills. But it has evolved.

I mean, there has been a license there for the HMO's to come to HCFA and help themselves to Government funds, that not many have taken advantage of, but those who have done it have done it in a most creative and successful manner.

And I think you're right. I think the system is excellent, and in my district—I happen to be somewhat parochial—I think Kaiser has done an outstanding job, but not because of any rules. Just because it has been there a long time and evolved, and the community pressures—whatever they are—have worked.

I think that we need some restrictions to see that system expand.

Dr. **Lee**. Unfortunately unscrupulous business practices are not restricted to Wall Street. They can involve medical care.

Chairman **Stark**. Or Congress.

Dr. **Lee**. Well, speak for yourself.

Chairman **Stark**. OK. Thank you. I am going to suspend here for a minute or two while the next witnesses come to the table, and see whether or not there is going to be a vote on the journal, which we will know as soon as the prayer is finished, and then we can proceed.

Dr. **Lee**. Thank you very much, Mr. Chairman.

Chairman **Stark**. Thank you very much. We appreciate it.

Our next witness is Dr. Chassin, who is the senior project director of the RAND Corp., and if he would like to find his way to the witness stand, I rather suspect we are going to have a vote in a moment, and it'll take us about 5 or 6 minutes to get over and back.

We have been spared the journal vote, I understand, so we will reconvene the hearings and look forward to hearing Dr. Chassin's testimony.

Would you please proceed to summarize or expand on your testimony in any way you're comfortable. Your complete testimony will, without objection, appear in the record in its entirety. Welcome back.

STATEMENT OF MARK R. CHASSIN, M.D., SENIOR PROJECT DIRECTOR, THE RAND CORP., SANTA MONICA, CA

Dr. **Chassin**. Thank you, Mr. Chairman, members of the subcommittee.

My name is Mark Chassin. I am a practicing physician in addition to being a health-services researcher. Also, I was Deputy Director of the Office of PSROs at HCFA for 2 years, from 1979 to 1981.

Thank you very much for inviting me to testify this morning.

The problem of unnecessary health services has been debated at the national level for well over a decade, at least since the Moss committee report and hearings in the mid-1970s.

This debate, while often heated, has generated little light, in my view, primarily because of a lack of information on the magnitude and extent of the problem.

I would like to describe to you this morning the results of a study that we have recently completed at the RAND Corp. and UCLA that you've heard some about already, that I think does begin to illuminate the issue.

We studied the appropriateness of health services delivered to Medicare beneficiaries. In doing that we first had to create a method to develop standards of appropriateness against which to measure actual medical practice.

This method combines a thorough review of the medical research literature with expert physician judgment

The literature view summarizes what's known about the effectiveness of particular diagnostic or therapeutic procedures.

Based upon this review, we then create a list of specific clinical circumstances, called indications, in which the use of a particular procedure might be considered.

These lists are necessarily long and detailed. We take into account every factor that physicians ordinarily consider in making a recommendation to a patient concerning one of these procedures.

We then send this list to a panel of nine expert physicians representing all specialties caring for patients who might become candidates for procedures we are studying.

The physicians rate each indication on a scale of appropriateness and then have a face-to-face discussion about areas where they disagree. Then they rate the indications again.

It is important to note that our definition of appropriateness is a purely medical one. The benefits of the procedure should outweigh its risks.

We exclude considerations of cost from the definition. This process results in the creation of a complete catalog of indications or reasons for doing a procedure, with each one rated as to its appropriateness.

For purposes of reporting results we classify indications into three categories: appropriate, benefits outweighing risks; inappropriate, risks outweighing benefits; and equivocal, risks and benefits are about equal.

We used standards generated in this way to measure the appropriateness with which three procedures were performed in the Medicare population in 1981.

Coronary angiography, upper gastrointestinal endoscopy, and carotid endarterectomy.

We studied community practice in 5 large geographic areas, together representing 2 million Medicare beneficiaries.

We reviewed office and hospital medical records to determine the specific indication for each of 4,564 randomly selected cases.

We then matched the indication identified for each case against the standards developed by our panels to determine appropriateness.

As has already been discussed, we found evidence of substantial inappropriate use. One in six, or 17 percent of coronary angiographies and upper GI endoscopies, was inappropriate, as was 1 in 3, or 32 percent of carotid endarterectomies.

At least as important for this procedure, for carotid endarterectomy, we also were able to measure complication rates.

We found that 3.4 percent of patients died within 30 days of the procedure, and an additional 6.4 percent suffered nonfatal strokes during or immediately after surgery for a total major complication rate of nearly 10 percent.

Many experts agree that if the major complication rate from carotid endarterectomy is much greater than 4 or 5 percent, its value, under any circumstances, must be considered highly questionable.

We believe that there are several ways in which this method of assessing appropriateness can help improve quality, and hopefully reduce costs as well in the Medicare program.

For example, appropriateness standards could be used as part of a program that required prior approval for certain procedures.

If used this way, I would urge that our method not be used as absolute proof of inappropriateness in an individual case, but rather, as a screening device that would help find cases with a high probability of being inappropriate.

A final determination should be made only after case-specific review. There are other uses for appropriateness standards and assessment. They can be an important component of periodic quality and utilization assessments for physicians and hospitals.

They can be used as one of the bases for selecting physicians or hospitals for PPOs. And in addition, standards that are clinically detailed and are established by well-respected groups of physicians can, I think, be powerful educational devices for improving physician practice.

In summary, we developed an effective method of assessing the appropriateness with which major medical and surgical procedures are performed.

We found substantial inappropriate use of three common procedures among the Medicare population in 1981.

For the one procedure for which we were able to look at complications, we found that the cost of the inappropriate use of health services is measured in human as well as monetary terms.

We believe the Medicare program can use methods like ours to help reduce the inappropriate use of health services.

This method is one of the very few that offers us the opportunity to reduce costs and improve quality at the same time.

Thank you very much. I would be happy to answer questions.

[The statement of Dr. Chassin follows:]

Statement Submitted to the House Ways and Means Committee
Subcommittee on Health
Payment of Physicians By the Medicare Program
Mark R. Chassin, M.D., M.P.P., M.P.H.
Senior Project Director
The RAND Corporation
May 24, 1988

The problem of unnecessary health services has been debated for many years to little effect. The issue was first raised to national prominence in the mid-1970s by the Moss Subcommittee. Some have maintained that very little, say 1-2%, of what medicine provides to patients is of no benefit. Focusing on these services will, therefore, lead to little cost savings even if all of them could be eliminated. The major public policy problem in health, in the eyes of these observers, is that we must choose whether and to what extent to employ services with high cost and little benefit. Therefore, in order to reduce expenditures we must forgo effective services.

Others have argued that a large proportion of medical services is unnecessary, perhaps up to 30%. Proponents of this position claim that before choosing to reduce the use of necessary and effective services, we should eliminate unnecessary ones. By eliminating such services, we may be able to contain costs while simultaneously enhancing quality of care by eliminating the risk of unnecessary services.

For many years this debate has proceeded without resolution, largely because of a lack of scientific data on precisely how many and what kinds of health services are provided for medically inappropriate reasons. In the last year, we have begun to see some data emerging that can help inform the debate. In this statement I will describe the results of a study performed by a research team at the RAND Corporation and the UCLA Medical Center that: 1) developed a method for assessing the appropriateness of major medical and surgical procedures and 2) measured the appropriateness with which three common procedures were performed in the Medicare population in 1981. I will also discuss the uses to which I believe this method of assessing appropriateness can be put.

Assessing Appropriateness: A Method

The RAND/UCLA Health Services Utilization Study developed appropriateness standards for six procedures commonly performed on Medicare patients: coronary angiography, coronary artery bypass surgery, upper gastrointestinal (UGI) endoscopy, colonoscopy, cholecystectomy, and carotid endarterectomy. One of the most difficult challenges we faced in accomplishing this task was to create the method by which such standards could be produced. We began by examining the medical research literature on each procedure. We expected to uncover data documenting the circumstances under which a procedure had been proved to be effective and those under which it had been proved ineffective and, therefore, inappropriate.

While we expected that the literature would have some limitations, we were not prepared for the remarkable dearth of data we found. For some procedures, not a single rigorously scientific study could be found relating to effectiveness. For others, a few such investigations were available. Even when we found many such studies, (e.g., twelve for coronary artery bypass surgery), they were focused narrowly on one or two subgroups of patients, failing to provide effectiveness data on a wide range of potential uses of the procedure.

We concluded, therefore, that the research literature, while it provides some essential data on appropriateness, is an insufficient information base by itself from which to build standards for the appropriate use of medical and surgical procedures. This is particularly true when the goal is to develop such standards for all possible uses of a procedure.

At this point some argued that such standards could not be created, given the lack of scientific data on effectiveness we found; the effort should be postponed until such data became available. We believed then, and I still believe, that useful standards can be created in the face of imperfect data on effectiveness. To accomplish this task, we employed a structured process of consensus building that blends existing scientific data on effectiveness with expert physician judgment.

The first step in this consensus process is a comprehensive review of the research literature, summarizing what is known about when a procedure is effective and when it is not. From this literature review, we then construct a comprehensive catalog of clinically specific reasons, or indications, for the procedure. In building this catalog, we take into account all of the critical factors that a physician ordinarily considers in making a recommendation to a patient concerning the procedure. Because this is a complex process, it frequently results in the creation of many indications, several hundred for most procedures, and close to 1000 for some. Such detail is necessary to define subgroups of patients specifically enough to enable physicians to make clinically sound judgments on appropriateness.

The next step is to select a panel of expert clinicians to judge the appropriateness of each indication for each procedure. We select nine physicians from various regions of the country, from academic as well as community practice, and from all specialties relevant to the care of patients who become candidates for the procedure under consideration. This last point deserves emphasis. We strongly believe that appropriateness is best judged by a wide range of physicians, not simply those who perform the procedure for which standards are being developed.

The panel of physicians receives the literature review and rates each indication on a nine-point scale of appropriateness. definition of appropriateness is a purely medical one. We consider a procedure appropriate if its expected health benefits outweigh its expected negative consequences, both broadly defined, by a sufficiently wide margin that the procedure is worth doing. It is important to note that our definition of appropriateness is a purely medical one. Cost does not enter into the definition of appropriateness. On our scale, 1 = extremely inappropriate, 5 = equivocal (risks and benefits about equal), and 9 = extremely appropriate.

The rated indications are analyzed to determine for which ones disagreement exists. The panel then convenes for a face-to-face clinical discussion of appropriateness, focusing on areas in which the first round of ratings showed disagreement. Following the discussion, panelists rate the indications again. This process results in the creation of a catalog of indications with each one rated as to its appropriateness. This consensus process does not force panelists to agree. If disagreement persists after the discussion, it is reflected in divergent ratings on the second round. We have found, however, that the process decreases disagreement in virtually all cases.

We now have wide experience with conducting physician consensus panels to rate the appropriateness of medical and surgical procedures; we have even conducted such panels in the United Kingdom. We have studied the reliability and validity of the appropriateness ratings that result from the panels and believe there is strong evidence for both. We hope that further research will allow us to improve on what exists, but we believe that the current method produces medically sound standards of appropriateness. The list of references at the end of this statement includes published reports and papers describing the method, the standards of appropriateness it creates, and its reliability and validity.

For purposes of reporting results, we have classified indications into three categories: appropriate, equivocal, and inappropriate. Appropriate indications are those which received median ratings of 7-9 without disagreement. Inappropriate indications received median ratings of 1-3 without disagreement. Equivocal indications are those which received median ratings of 4-6 or indications demonstrating disagreement, regardless of median rating. For these purposes disagreement was defined as present if at least three panelists rated the indication appropriate (7, 8, or 9) and at least three panelists rated it inappropriate (1, 2, or 3).

Assessing Appropriateness: Results

We used the standards of appropriateness for three procedures to assess medical practice in 1981. The three procedures we studied were: coronary angiography, UGI endoscopy, and carotid endarterectomy. We identified five large geographic sites in which to perform the study. These sites are widely scattered geographically, including areas from each major census region. They also span the spectrum of urbanization, from mostly rural to mostly urban. Two million Medicare beneficiaries lived in these sites in 1981. In two sites we studied the use of all three procedures; in the other three sites, we studied one procedure each.

Our goal was to study community medical practice. To this end, we used Medicare physician claims data to select a random sample of Medicare patients who had received one of the three procedures in 1981. We then recruited the participation of the physicians who performed these procedures. A remarkable 819 or 90% of physicians participated in the study by allowing us to review the hospital and office records of their patients; 99% of hospitals participated.

We reviewed the medical records of 4564 patients and determined the specific indication or indications for the procedure each one received. We then matched the indications identified for each case against the standards developed by our panels to determine the appropriateness of each case for each procedure.

We found that appropriateness varied much by procedure but little by geographic area. The Table below summarizes these findings.

Appropriateness of Use of Three Procedures in 1981 Among the Elderly

		Appropriateness Category (%)		
Procedure	Site No.	Appropriate	Equivocal	Inappropriate
Coronary Angiography	1	72	10	18
	2	77	7	17
	3	81	4	15
	All Sites	74	9	17
Carotid Endarterectomy	1	37	34	30
	4	30	40	40
	2	42	29	29
	All Sites	35	32	32
UGI Endoscopy	1	72	14	15
	2	73	8	19
	5	71	11	18
	All Sites	72	11	17

Overall, 17% of coronary angiographies and UGI endoscopies were inappropriate as were 32% of carotid endarterectomies.

When we examined in greater clinical detail the kinds of cases classified as inappropriate, we found that the vast majority of these cases represent circumstances in which virtually all clinicians would agree that the procedure should not be performed. For example, about half of the inappropriate carotid endarterectomies were performed on patients with less than 50% obstruction in the operated carotid artery. About half of the inappropriate coronary angiographies were performed on patients without angina, who had not undergone previous exercise testing. One of the frequent inappropriate reasons for endoscopy was its use to document the presence of a duodenal ulcer within two weeks of an x-ray that had shown the same finding. These are not areas where reasonable physicians can reasonably disagree. They represent clearly inappropriate practices.

For one procedure, carotid endarterectomy, we had the ability to measure directly the outcomes of care. We found that the mortality rate from this procedure within 30 days of surgery was 3.4%. In addition, 6.4% of patients suffered nonfatal strokes during or immediately after the procedure. Many experts agree that if the complication rate (death plus nonfatal stroke) for this procedure is much greater than 4-5%, its value under any circumstances must be considered highly questionable. Among the inappropriate cases, the mortality rate was 3.4% with an additional 7.4% of patients with nonfatal strokes.

We concluded that a substantial proportion of procedures was performed for inappropriate indications in 1981. In reviewing the major reasons why cases were classified as inappropriate, we did not find any evidence to suggest that current practice is any more appropriate. And we found substantial complications associated with the inappropriate use of the single therapeutic procedure we studied, indicating that inappropriate procedures can have a high cost in terms other than dollars.

Using the Appropriateness Assessment Method

We believe that using a clinically detailed method of assessing the appropriateness of major medical and surgical procedures can be an effective way of improving the quality of health care while perhaps containing costs at the same time. We see three principal ways in which the method can be applied: as part of a precertification system before procedures are performed, as a tool to evaluate appropriateness retrospectively, and as an educational tool for physicians.

It is now commonplace for health care payers to require prior approval before major elective medical and surgical procedures are performed. At the time this approval is requested, one could easily collect clinical information, detailed enough to determine the specific indication for the procedure. Appropriateness standards, developed by our method or another, could then be applied to this information and a determination made as to whether or not each case appears to have sufficient clinical justification to warrant approval. Further review of cases appearing to be inappropriate could then be instituted.

We believe that the proper role for appropriateness standards such as the ones we developed is to serve as screening criteria not as unequivocal proof of inappropriateness in an individual case. Once identified as highly suspect, an individual case should then be thoroughly reviewed to ensure that no idiosyncratic patient factors exist that might justify performance of the procedure despite failure to meet the appropriateness standards.

The retrospective use of the method is exactly analogous to the manner in which it was employed in the research project. Studying the appropriateness of the past use of procedures allows us to discover specific quality of care problems and assess their magnitude. It also permits focusing of scarce quality assurance resources where documented problems exist. A retrospective assessment of appropriateness might become part of a periodic Medicare quality assessment for physicians or hospitals or both.

Finally, we believe that appropriateness standards can serve as powerful educational devices to improve physician practice. When they are established by well-respected physician groups, practicing physicians will pay attention to them. In addition, both the prior approval approach and the retrospective assessment of appropriateness can be employed in an educational manner to show physicians how their own practice or that of their medical group or hospital compares with respected standards.

Conclusions

We developed appropriateness criteria for six common medical and surgical procedures using a method that combines scientific data from a review of the medical literature with expert physician judgment obtained by a structured consensus process. We studied the appropriateness of use in community practice of three of these procedures in 1981. We found that among Medicare beneficiaries, one in six coronary angiographies, one in six UGI endoscopies, and one in three carotid endarterectomies was performed for medically inappropriate reasons.

These methods can be applied to current reimbursement systems to assist in the process of identifying and eliminating inappropriate health services. They can also be used to educate physicians regarding the appropriate use of major medical and surgical procedures. We believe that using methods like these to reduce the inappropriate use of health services can have a substantial impact on health care costs while improving quality of care at the same time.

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Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. No questions at this time.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Dr. Chassin, I am not quite clear how you take your findings to the next step.

How do you use it as a control mechanism, in practice?

Dr. **Chassin**. One specific way in which standards of appropriateness can be used, is as I hinted a little bit in my statement—is to collect clinical information as part of a prior certification program. Many insurers now do preadmission review, preadmission certification.

Before procedures are performed, physicians and patients give information about why the procedure is necessary.

That information can be collated prior to the time the procedure is done, if the procedure is elective, that is, and a determination can be made about what the indication is for the procedure.

If standards like ours were used, we would then basically look up that indication in our catalog, and figure out whether the experts had said that it was appropriate, equivocal or inappropriate.

We would approve indications, cases with indications that were appropriate, and cases that looked inappropriate, based on that screening device, could then be subjected to further review before a final determination was made.

Mr. **Levin**. I know that is listed as the first possibility, but build it into the Medicare system with tens of thousands of people. So how does certification work?

I mean, you cannot do this strictly by computer, right?

Dr. **Chassin**. No. You do a lot of it by computer. What would actually happen, as a practical matter, is the patient, or the physician, or a combination, would call a trained nurse who would collect this clinical information over the phone, by and large.

And for many procedures, that process alone, which could take as little as, oh, 20 or 30 minutes of conversation, would result in a determination that the procedure is appropriate.

In about 70 to 74 percent of two of the procedures we studied, the indications were appropriate, the cases were appropriate. So, for the vast majority I think of most procedures, you could, within 20 or 30 minutes, determine that they were appropriate, no further review is necessary, and approve them very expeditiously.

The ones that did not pass the screen, that looked inappropriate based on the clinical information that was obtained, would then be the subject of further intensive review, and probably the best way to do that is with a physician to physician contact, so that a reviewing physician would look at the clinical information, call the treating physician, find out if there are any idiosyncratic patient factors, anything unique about the patient, that would suggest the procedure is appropriate, despite its failing to pass the screen.

If that was true it could be passed again. But at that point I think you need a little bit more review. But again I think it could be done in a practical and expeditious way.

Mr. **Levin**. Is this happening anywhere in the world?

Dr. **Chassin**. Well, there are many insurers——

Mr. **Levin**. There is some of it with private insurers. They are doing it for all procedures where the physician calls—is there that certification process——

Dr. **Chassin**. Not for all procedures, but for most major elective procedures. Clearly, any procedure that is done on an emergency basis cannot be reviewed in this fashion, but many insurers have programs where clinical information is required before approval for payment is granted, prior to the procedure being done.

Mr. **Levin**. What is the largest unit using it now?

Dr. **Chassin**. Many Blue Cross plans, many private insurers. Aetna.

Mr. **Levin**. For all procedures of a certain kind?

Dr. **Chassin**. That is right. Basically elective procedures. Some have even outpatient review processes now for outpatient procedures.

Mr. **Levin**. Do you think they are effective? Have you studied them?

Dr. **Chassin**. We have not studied them. I think that they can be effective if they use detailed, clinical standards of appropriateness, and most of the ones I am familiar with at this point do not use standards that are detailed enough to really discriminate well, appropriate from inappropriate services.

I think that is the part of the process that has been lacking thus far.

Mr. **Levin**. So your guess is that where it is used, in many instances, anyway, it is kind of pro forma?

Dr. **Chassin**. Yes. I think that is right.

Mr. **Levin**. So if you have not studied these, you would not have any information as to where it is really working?

Dr. **Chassin**. No.

Mr. **Levin**. What do you think would be the reaction of the medical profession to the system you outlined?

Dr. **Chassin**. Well, I think the reactions would probably be somewhat diverse. However, I think that this approach offers—and one of the reasons that we tackled the problem in this fashion, is that it offers the profession a chance to participate actively in the process of public programs trying to reduce costs.

It is a medically rational way to approach the problem, by trying to segregate services that are inappropriate, that have no benefit, and in fact convey some harm in many instances, and reduce selectively, the use of inappropriate services.

I think physicians who understand that kind of problem, this problem in specific, will be very enthusiastic about it.

Our method really focuses on the use of procedures for clearly inappropriate reasons.

For example, any indications where our panels disagreed about appropriateness, we did not classify as appropriate or inappropriate. They are in the equivocal category.

So we are really talking about practices that virtually no reasonable physicians can support, and at least as a political matter, starting at that end of the spectrum I think is the best way to go and will receive positive reception.

Mr. **Levin**. No reasonable physician, but the numbers show inappropriateness of 17, 32, and 17 percent.

Dr. **Chassin**. That is right.

Mr. **Levin**. Thank you.

Chairman **Stark**. Are you familiar with the Canadian system and the recordkeeping, in particular, that goes on with their physician reimbursement?

Dr. **Chassin**. I am not sure I know what you mean by——

Chairman **Stark**. Well, it is my understanding that the records that are kept for the Canadian reimbursement system are much more extensive than the records we have in this country.

Admittedly, they are only dealing with 25 million people, but, it is my understanding that every physician's timecard is cross-indexed, and in a computer I am not sure whether those are the facts or not, but that is my layman's understanding.

Second, we heard Dr. Lee suggest that the physicians in Canada feel that they have less restriction and third, that perhaps there are fewer inappropriate procedures.

If all those things are correct, and with the fact that they keep closer records, and have the knowledge there—without even going through more utilization review—which I gather they do not do—in Canada—there may be some way that the message jumps out.

But is it conceivable that just knowing that the information is kept and catalogued might have some reduction in overutilization without the regulations being necessary?

Dr. **Chassin**. I am not aware that any of the provinces have recordkeeping systems that would keep information detailed enough to judge appropriateness from a clinical standpoint.

They do keep better and more complete, from the standpoint of looking at episodes of care, more complete information about treatments, diagnoses, and procedures.

At least in Manitoba they are quite reliable, and have been used in health-services research for a long time.

I do not believe there is any significant utilization review in Canada, in at least most of the provinces that I am aware of.

Chairman **Stark**. I guess what I am saying is: do not those records in and of themselves control utilization?

Let's suppose that you are dealing with a population of a thousand interns, and that 2 or 3 percent of those internists do 50 times more of a certain test or procedure per number of patients.

Doesn't that automatically indicate something unique? And that isn't utilization review; that is just knowing that the record printout, which is there for inspection by your peers, might in itself control utilization. That is what I am getting at.

Dr. **Chassin**. I am not aware that that sort of detailed utilization data is routinely made available in most provinces in Canada. It certainly is——

Chairman **Stark**. It is available. I mean it is there, and it is collected.

Dr. **Chassin**. I do not know that that would have—there is some work to suggest that feedback of information to specific physicians on their own utilization patterns can be a very useful way to modify practice, especially when it is accompanied by clinical information about why the practice seems different.

There clearly are hazards with that sort of information because it does not really give you much of an explanation of why there are differences among physicians in how they use services, but it can be a useful way to modify physician practice, if it is amplified with clinical information.

Chairman STARK. In your study, what kind of objections did you receive from your peers? Was your study generally accepted by the professions, or was it criticized as being draconian?

Dr. CHASSIN. Well, we have had a number of different kinds of reactions. Some people have said that, for example, it looks at practice in 1981, and 1988 as different, and we have looked at—tried to estimate changes that have taken place between 1981 and 1988, and really do not find that there is a whole lot of reason to think that—there is certainly no hard data suggesting that things are much different in 1988.

We have also received a lot of support for the finding that the complication rate, for example, for carotid endarterectomy, is much too high, and in fact a lot of dismay from the specialty societies that are connected with that procedure.

On the other hand, there has been very little dispute, for example, with our finding of 32 percent inappropriate carotid endarterectomies.

When you look at the clinical detail behind that finding, half of those procedures were done on arteries with less than 50 percent obstruction, which is to say virtually insignificant obstruction.

And those sorts of clinical findings—there has been very little dispute. There are a few indications which may have changed over time, but the vast body of the data I think still holds up in 1988.

Chairman STARK. Thank you very much. We appreciate it.

Mr. LEVIN. Could I ask one last question?

Chairman STARK. Sure.

Mr. LEVIN. Maybe it is an inappropriate question. It is not equivocal. Are these three procedures very atypical? Or to put it another way, would you expect inappropriate rates to be nearly this high if you took three other types of major procedures?

Dr. CHASSIN. That is a very good question. We picked these procedures because they are commonly used in the Medicare population. We did not pick procedures that looked, before we did the study, as though they were clearly overused, and really ought not to be used at all.

So we picked procedures that generally were perceived to be in the mainstream.

I can give you one other piece of information to help inform the answer to that question, which is a study that was done on pacemaker insertion, not using our method, but using the same general approach of setting appropriateness standards, looking at documentation for why procedures were done.

In fact in that study they went back to the hospitals and asked them to look at the information that had been collected, and to refute it if there was additional information that could be used.

They found 20 percent in the Medicare population, 20 percent of pacemaker insertions were inappropriate or unwarranted.

I think that based on my clinical experience, and my experience within the PSRO program, that 32 percent may be on the high side, but 17, 15, 20 percent is not going to be unusual as we start generating more information about commonly used procedures.

Mr. **Levin**. Why such a high figure?

Dr. **Chassin**. Well, I think one of the reasons that those figures generate some surprise, and particularly in the medical profession, is that there is a problem of viewpoint.

When physicians that are in the mainstream of medical practice look at the appropriateness of what they do and what their colleagues do, they see the mainstream. They do not see the periphery.

And here, I am not reflecting research because we have not looked to see whether there are differences among different kinds of physicians in the level of appropriateness.

I am reflecting my clinical experience and my experience in helping to run the PSRO program. They do not see the periphery, and there are some rather astonishing practices in the periphery.

What the debate has focused, in large part, in the absence of data, on is whether the periphery constitutes one-tenth of 1 percent, and yes, we have to worry about it because we cannot tolerate that sort of practice in the medical profession at any level, but it really cannot influence our thinking about quality assurance as a whole, or cost containment because it is such a narrow subset.

Or whether it is a substantial fraction of use, cost, and quality problems. And I think what we are beginning to see with our work and with the work of others, that the periphery is a substantial slice of medical practice that needs to attract our attention both from the standpoint of cost containment and quality assurance.

Mr. **Levin**. Thank you.

Dr. **Chassin**. Thank you.

Chairman **Stark**. Our next witnesses will appear as a panel. I am pleased to welcome Dr. Ball who is the executive vice president of the American College of Physicians, who I note is also a lawyer, and must thereby have trouble living with himself; and Dr. Jerry Austen who is chairman of the Committee on Reimbursement of the American College of Surgeons, who will have to refute Dr. Roper's testimony, who thinks it is unfair, that he has the same diploma as a pediatrician that Dr. Austen has as a surgeon, and he gets less.

I would tell him that both Jerry and I got diplomas from MIT at around the same time and I know he makes twice as much as I do, and that is unfair, but I think Dr. Roper has the better part of that argument.

Completing the panel is Dr. Robert Graham, who is the executive vice president of the American Academy of Family Practitioners.

I would like to submit to all the other subspecialty groups in the world, that the selection of this group of witnesses does not mean that they have sold out to socialism by appearing here, or that we have prejudiced any other subspecialties and/or any other umbrella organizations.

I think we are going to be debating these issues for the next several years.

I hope that all the members of the medical community feel that they will have ample opportunity for their views to be heard, perhaps more by the time we are done than they ever hoped for.

And saying that, I welcome all of you to the first of these discussions and look forward to your testimony.

Chairman STARK. Those lights are really for nothing more than to give those of us up here who tend to be a little more long-winded than others some notice of how long we're running.

Your prepared testimony will appear in the record in its entirety, and you can paraphrase it or expand on it or read it, in whichever manner you're comfortable.

So, Dr. Ball, would you like to start first?

STATEMENT OF JOHN R. BALL, M.D., J.D., F.A.C.P., EXECUTIVE VICE PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. BALL. Mr. Chairman, thank you for your prefatory comments on our inclusion. We are pleased to have the opportunity to appear today.

As we've testified before this committee previously, we support the goal of long-term reform of the Medicare physician payment system. Our common goal ought to be to pay at appropriate levels for appropriate services, and not to continue to pay at inappropriate levels for inappropriate services.

I'd like to address briefly a few of the issues that the Physician Payment Review Commission raised in their report. I'll do that in the order they raised them, saving for last what I think we all believe to be the most important, and that is utilization and appropriateness and quality guidelines.

First then, in their order, the relative value scale.

The American College of Physicians was one of the first to propose, and interestingly enough with the American College of Surgeons, and we've consistently supported the concept of the relative value scale.

We have been supportive of the Harvard study. We are very pleased with the work plan that the PPRC has outlined to evaluate the research, including hearings and simulation and other analytical work. We do have a number of concerns about the Harvard research that we will be asking the PPRC to explore. First, for example, it may be difficult to tease apart all of the discrete tasks involved in delivering services as complex as those of the internist.

Second, we will want to better understand the extrapolation of values from some two dozen services and procedures surveyed within each specialty to all services and procedures.

Third, we've got some questions about the linking of relative values across specialties.

And, fourth, in the study there is no measure of severity, a problem that might open up the RVS to criticisms similar to those made about DRGs.

However, those particular concerns that we've expressed, while important, are largely methodological issues. And as we would do with any scientific study, we'll consider them fully when the results are released. We will be pleased to work with both this committee and the Commission on these issues.

We do, however, urge Congress to maintain a distinction between the RVS study itself and the politics of implementing the research through a Medicare fee schedule. There will be attacks—you've already heard those—on the methodology which stem from fears of the financial impact of a fee schedule, fears enhanced by expectations of a zero-sum game associated with a fixed level of spending. We have the opportunity here to set Medicare payment levels on the basis of an objective measure of the relative work done by physicians rather than on historical payment levels.

We must be careful to evaluate that measure separately and apart from our consideration of the issues of converting it to a fee schedule. Careful examination by the PPRC will help assure that this happens.

The next issue is that of specialty differentials. As the PPRC has indicated, differences among specialties in the time, effort, skill and judgment involved in providing services billed under the same procedural codes are often not recognized by the payment system in a rational manner. The college believes that there may indeed be recognizable differences in the content, quality and value of seemingly similar services provided by different specialists. The judgment and expertise of the more qualified and experienced specialist would appear to justify higher payments in certain cases. We agree with PPRC that this is an area that requires more careful analysis.

We don't understand, however, the basis for HCFA's recent notice of proposed rulemaking, to eliminate most specialty differentials at a time when major reform of the system is under consideration. We recommend that no abrupt action be taken until after completion of the kind of study and careful analysis outlined in the PPRC report.

We suggest, for example, that the committee comment on the HCFA proposal and, if necessary, consider a legislative provision to maintain current rules.

Next issue, that of assignment. The Commission, we believe, has done a scholarly job in examining the current status of Medicare assignment and summarizing options for modifications. While the analysis is thorough, it has been conducted within the rather narrow confines of our existing notions of assignment and the participating physician program.

As it has done with other policy issue, we suggest that the Commission should frame broader questions, broad enough to generate new thinking about possible alternative solutions to this challenging issue.

And, finally, the important issue of utilization and practice guidelines. For the American College of Physicians, the question of utilization is not a new issue, but one that has been a part of the traditional scientific mission of the college. We believe that it is possible and even desirable to develop medical practice guidelines which can be a very powerful tool in shaping overall practice patterns to reflect the best medical judgment on appropriate utilization of services.

Over the last dozen years, the college has made a major commitment to this activity through our clinical efficacy assessment project, and it is this project which the Commission has cited as central in the development of their own thoughts on this issue. The essence of our work is to synthesize the best scientific information on the questions of which interventions are effective and which are inappropriate or obsolete, and under which circumstances they are appropriately utilized.

Using sound guidelines, we can change physician behavior, a task that does require a combination of education, utilization review, and financial incentives. Information which is scientifically based and from a credible source is often sufficient enough to change behavior. At some point, however, if educational efforts fail to bring about appropriate utilization of a specific service, then financial incentives do become a tool for controlling overutilization.

The college has argued for a long time that neither outmoded or ineffective procedures, nor procedures inappropriately utilized, should be reimbursed. We believe that responsible medical professional societies should identify procedures and services where there's a strong consensus on appropriate practices based on data and scientific studies, and should undertake intensive educational campaigns to promote these guidelines and advise physicians on necessary changes in practice patterns. If Medicare uses guidelines developed by the profession, as stated in the PPRC report, "with full appreciation that appropriate care depends on the particular clinical needs and preferences of the patient, and that the clinical judgment of the attending physician must be respected," then good medical practice will determine payment decisions, and we can support this, as opposed to payment decisions determining medical practice, which we do not support.

We appreciate again the opportunity to appear before you, and will be pleased to respond to any questions that you might have.

Thank you.

[The statement of Dr. Ball follows:]

STATEMENT

of the

AMERICAN COLLEGE OF PHYSICIANS

before the

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

May 24, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to present our views on physician payment issues. I am John R. Ball, M.D., J.D., F.A.C.P., Executive Vice President of the College.

The College represents 65,000 physicians in internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Approximately one-third of the ACP members are Fellows of the College (FACP), a designation based upon their having met standards of scholarship and contribution to the science and practice of medicine beyond their eligibility for board certification in internal medicine.

BACKGROUND

As we have testified before this committee previously, we support the goal of long-term reform of physician payment under Medicare. Reform must be guided by three basic principles, which can be summarized briefly as: assurance of access to care, assurance of high quality care, and reasonable cost to ensure affordability of care. These are goals shared by the Physician Payment Review Commission (PPRC), and we are confident that their recommendations for payment reform will reflect these concerns.

Mr. Chairman, one of the most promising steps taken by Congress to achieve long-term reform of Medicare payment was the creation of the PPRC. Their vision has been broad, their proposals have been innovative, and their analysis data-based and careful. We congratulate the Commission on its 1988 report, and look forward to continuing to work with the Commission and its fine staff.

We are committed to helping craft proposals which assure that Medicare payments are set at appropriate levels, and are made for appropriate services only. The role of the medical profession to set standards for itself will be central in that effort.

RELATIVE VALUE SCALE

The American College of Physicians has consistently supported the concept of a Relative Value Scale. In fact, we were one of the first to propose that payments should reflect the resources used by physicians in doing their work, and the College of Physicians joined with the College of Surgeons in submitting a proposal to undertake the RVS research. We continue to believe that the RVS will provide an instrument that can be used to design a payment system meeting the following objectives:

- the system should be based on quantifiable, objective data, rather than on historical charges which may have little relationship to the work and resources involved in providing services;
- the system should pay appropriately for appropriate services;
- it should not perpetuate incentives for excessive, outmoded, or ineffective services;
- it should be flexible enough to foster effective innovation and to be modified in the face of valid changes in medical practice.

We are generally supportive of the RVS study being conducted at Harvard, and we are pleased with the workplan the PPRC has outlined to evaluate the research, including hearings and simulation and other analytical work. We have a number of concerns about the Harvard research that we will be asking the PPRC to explore. For example, we are concerned that it may be difficult to tease apart all of the discrete tasks involved in delivering services, and accurately estimate time and intensity that reflect the sum total of these tasks. Asking an internist to estimate the work involved for a day-three, post-admission hospital visit for a myocardial infarction is very different from asking a radiologist to estimate the work involved for an x-ray reading. In the visit for the MI patient, the internist may: review the chart, examine the patient, review an x-ray, examine microbiological slides, examine pathological slides, discuss with consulting physicians, write and/or dictate notes, and talk with the family. To the extent that survey respondents were not prompted to think about all of these and other discrete tasks, the scores assigned could be underestimated.

We will want to better understand the extrapolation of values that was made from the approximately two dozen services and procedures surveyed within each specialty to the entire range of services and procedures. Dr. Hsiao has accomplished this by creating "families" of related services, and using ratios of Medicare charges to assign relative values to the non-surveyed services--thereby locking back into the system all the vagaries and inequities of historical charges. While we realize it was not possible to survey all services and procedures, we will urge the Commission to examine this issue.

Another issue which deserves attention is the linking of relative values across specialties. The researchers have identified services which are comparable between specialties, and used those links to associate their relative values. There are only a few of these links, however, and there are specialties for which no comparable services may be found in other specialties. The Commission should examine the efficacy of this methodology, and any alternatives.

The Harvard research does not include any variation for patient characteristics, beyond that afforded by codes of the Common Procedural Terminology (CPT-4). Most importantly, there is no consideration of a measure of severity, a problem which may open the RVS to criticisms similar to those made about DRGs. The reason given for omitting a severity adjustment is that there is no agreed-upon way to measure the concept. While that is true, it is not clear why this concept is any more subjective or difficult to derive estimates for than other factors such as intensity which were measured in the project.

The concerns we have expressed, while important, are largely methodological issues--and as we would do for any scientific study, we will consider them fully when the results are released. Only at that point can we judge whether these flaws are fundamentally damaging or can be worked out with technical corrections. We will be pleased to work with the Committee and the Commission on these issues. We would reiterate our central support for the concept of the RVS, and our intention to analyze the specific aspects of the Harvard study upon its public release.

In evaluating the effects of the RVS on physicians, it is important not to lump all physicians in a particular specialty together. Within specialties, there can be very different mixes of services among the four general categories used in the Harvard research--evaluation and management, invasive, imaging, and laboratory. Specialty societies can provide guidance on how best to subdivide specialists in order to gauge the impact of the RVS in a discriminating manner.

We also urge you to remember that the RVS is not a complete blueprint for physician payment. There are other elements which may have to be kept separate from a fee schedule and dealt with at a later time. Examples include laboratory services and diagnostic procedures with a high technical component--elements not central to the RVS research, but part of the workplan of the PPRC. While payments for these services may be considered separately, any changes must be balanced against changes made by the fee schedule.

We know that the Commission is aware of the complexities of these two issues, and we will work with them to formulate options.

Finally, we urge Congress to maintain the distinction between the RVS study itself and the politics of implementing the research through a Medicare fee schedule. As you know, there will be attacks on the methodology which stem from fears of the financial impact of the fee schedule--fears enhanced by expectations of a zero-sum game associated with a fixed level of spending. We have the opportunity, for the first time, to set Medicare payment levels on the basis of an objective measure of the relative work done by physicians. We must be careful to evaluate that measure separately and apart from our consideration of the issues of converting it to a fee schedule. Careful examination by the PPRC will help assure that this happens.

CODING REFORM

The PPRC has recognized the importance of coding in identifying and defining physician services, and has highlighted the need for coding reform in conjunction with development of an RVS. The College is in agreement with the PPRC's goals of developing codes that 1) are clear, standardized, and can be used consistently; 2) are simple and efficient for physicians to use and carriers to administer; 3) maintain incentives for physicians to provide appropriate services and do not impede beneficiary access to appropriate care; 4) distinguish among services which are different, allowing for differences in patients and in levels of physician skill and effort; 5) do not create inappropriate incentives that might interfere with clinical decision-making; and 6) can be implemented in an orderly and coherent manner without causing major disruptions for physicians or carriers. To achieve these goals, while further recognizing particular difficulties in accurately describing physician visit services, the PPRC has adopted a two-part strategy, which we also support.

This approach will allow the Commission to begin immediately on one track with standardization of codes for the roughly 6,900 technical procedures listed in CPT-4 and to proceed more cautiously on a separate track in determining the need for reform of the approximately 100 codes for visit and consulting services. The College will be pleased to work with the Commission and its staff in ascertaining the specificity and reliability of CPT visit codes and their correlation with resource costs. If the current system cannot provide a sound basis for valuing, reporting and paying for visit services, we will work with the Commission in developing feasible and acceptable approaches for coding reform.

SPECIALTY DIFFERENTIALS

Specialty differentials represent another area to which the PPRC has given much attention already, and, because of the complexity involved, to which it plans to devote much more deliberation. There are substantial inconsistencies among Medicare carriers in payment policies regarding specialty differentials. There is also no uniform government policy, or agreement in the profession, as to who constitutes a "specialist" (i.e. should the determination be based on self-designation, board certification, board eligibility, evidence of special training, etc.). Differences among specialties in the time, effort, skill and judgment involved in providing services billed under the same procedural codes are often not recognized by the payment system in a rational manner.

As the PPRC has indicated, development of a uniform fee schedule and coding reform could more equitably compensate for many of these differences, particularly for surgical and technical procedures, and might obviate the need for some specialty differentials. However, as the PPRC has also acknowledged, differences in the content of visits and consultations by specialty will be difficult to measure and to address through the coding system.

The American College of Physicians believes that there may indeed be recognizable differences in the content, quality, and value of seemingly similar services provided by different specialists. The judgment and expertise of the more qualified and experienced physician specialist would appear to justify higher payments. Provision for specialty differentials helps to assure that Medicare beneficiaries have access to specialized services. Consequently, we agree with the PPRC that this is an area that requires much more careful analysis, especially in light of the conjoint development of a relative value scale and a uniform fee schedule.

Although we are pleased with the deliberative work plan that the PPRC has proposed, at the same time we are alarmed by the hastiness of the Health Care Financing Administration's recent notice of proposed rulemaking that would eliminate specialty differentials in Medicare prevailing charges for all physician services, except perhaps medical visits and consultations. We do not understand the basis for this action at a time when major reform of the system is under consideration. We recommend that no abrupt action be taken -- either legislatively or by regulation -- until after completion of the kind of study and analysis outlined in the PPRC report. We suggest that this committee consider commenting to HCFA on the inappropriate timing of this announcement, and evaluate the need for a legislative provision that would maintain current rules until this issue can be considered as part of long-term reform of Medicare.

GEOGRAPHIC MULTIPLIERS

We support development of a cost-of-practice index. Clearly this is a critical adjustment that must be made in creating a fee schedule that is fair to physicians in different practice settings and in different parts of the country. We also support development of specialty-specific indices that reflect different costs for liability insurance and other overhead expenses.

Payments should be adjusted also to take into account the cost of living in different areas. Like cost-of-practice, this is an element of fairness that would impose hardships in high-cost areas if not included. However, we are concerned about the Commission's attempt to modify cost-of-living adjustments by factors that reflect the desirability of different areas. We do not know why people locate where they do, what they value in an area, or how to turn that value into a monetary adjustment.

We are skeptical that the earnings levels of others, embodied in the notion of compensating wage differentials examined by the Commission, provides a means of making these adjustments. Again, who knows what factors have produced those differentials -- we cannot assume they are simply a function of a pure market -- or how they relate to factors that affect the behavior and incomes of physicians.

Finally, in this section, we support the work of the Commission to bring some rationality and consistency in definition in the drawing of the boundaries of localities for Medicare payment.

GEOGRAPHIC VARIATION

The Commission and its staff have done some pioneering work in attempting to reconcile existing patterns of variation in prevailing charges through the use of a cost-of-practice index. The analysis revealed that cost-of-practice differences explain relatively little of the geographic variation, and major inequities between urban and rural areas on average do not appear to be based on cost-of-practice differences. Adjusted urban charges were only slightly higher on average than rural charges. There was much variation among urban areas and among rural areas. Variations were greatest for visits and smallest for surgical procedures. For example, cost-adjusted 1987 data showed that only 63 percent of comprehensive office visits were delivered in areas where the prevailing charges were within a range of 80-120 percent of the national mean. In contrast, 88 percent of cataract removals fell within that range.

We support the Commission's desire to reduce this kind of variation, but we also agree that setting a floor and a ceiling for all services at this time would result in changes that may be opposite to those which will be indicated by the RVS, as well as in potentially dramatic changes for certain procedures in some areas. We agree with the more limited recommendation to set a floor of 80 percent of adjusted prevailing charges for primary care services (office, home, nursing home, and emergency room visits). This step will raise payments in low charge areas for those undervalued services most associated with access to care. The recommendation is consistent with goals for long-term reform of physician payment.

ASSIGNMENT

The Commission has done a scholarly job in presenting an examination of the current status of Medicare assignment, with relevant data, and in summarizing options for modifications. Our reaction, however, is that the analysis, while thorough, has been conducted within the rather narrow confines of our existing notions of assignment and the Participating Physician program.

As it has done with other aspects of payment policy, we suggest that the Commission should take a step back and frame questions broadly enough to generate new thinking about possible alternative solutions to this challenging issue. It would be extremely useful if the PPRC could elucidate principles that underlie the current quest for assignment and participation, as it may be possible to meet these objectives through other means. By articulating the goals which we hope to achieve, the Commission may develop new approaches beyond assignment and participation. In addition, evaluating the options identified in the report against a stated set of goals would help to foster a consensus that those are, indeed, the right choices for the Congress to consider.

For example, one goal might be "fairness". Is Medicare paying a "fair" price for services? Is the beneficiary paying a "fair" price? Is the broader health system paying a "fair" price, and what is the impact of these payments on Medicare? Does a disparity between the public and private sector perpetuate a view that the right to balance bill is necessitated by cross-subsidization?

Another goal of payment policy might be certitude or predictability of cost. What is the societal value for beneficiaries and for providers of knowing what the financial circumstances of delivering a particular service will be? Is this certitude more important under some circumstances than under others--for example, at certain income levels or at certain levels of price for the service?

These and other goals such as access, quality, limitations on the financial liability of individuals, and provision of appropriate levels of service are all affected by decisions that will be made on payment policy. We urge the Commission not to confine the standards by which it judges those decisions to the simple criteria of "increasing assignment" or "increasing participation".

UTILIZATION/PRACTICE GUIDELINES

For the American College of Physicians, the question of utilization is not a new issue, but one that has been part of the traditional scientific mission of the College. We believe that it is possible and desirable to develop practice guidelines which can serve as guidance to the physician as he or she makes decisions on treatments for individual patients. Widespread and appropriate use of such guidelines can be a powerful tool in shaping overall practice patterns to reflect the best medical judgment on appropriate utilization of services.

The College has made a major commitment to this activity through our Clinical Efficacy Assessment Project, and it is this project which the Commission has cited as central in the development of their own thoughts on the potential impact of practice guidelines. The essence of our ongoing initiative is to bring the best scientific information available to the question of which interventions are effective and which are inappropriate or obsolete, under what circumstances they are appropriately utilized, and when they are unnecessary. Our studies give us scientifically-derived benchmarks on indications for use, that may in turn guide decisions on appropriate levels of utilization. These benchmarks can then form the basis for efforts to identify services which may be over-utilized.

We should not give the impression that this is an easy task, or that using technology assessment to derive clinical guidelines is an exact science easily applicable to all medical technologies. Obviously it is a task complicated by all the factors that make medicine art as much as science, whose practice allows for reasonable and honest individuals to differ about what constitutes effective intervention under widely varying circumstances. Therefore, guidelines must always be applied with care and flexibility to take into account the experience and styles of its practitioners and the complexities of different patients in different circumstances.

The translation of a systematic review of medical technology into guidelines for appropriate practice should be regarded as a developing science. We should proceed, but cautiously, in this area. We hope that the Commission will initiate some experimentation on the questions of appropriate utilization, means of translating scientific data and standards into treatment decisions, and the measurement of outcomes. We recommend that Congress expand resources available for the technology assessments and outcome studies that are necessary precursors to development of guidelines. We urge you to ask your colleagues on the Appropriations Committee to support a small amount of funding which the Department of Health and Human Services has requested for new research in this area.

Assuming that we can develop guidelines for the use of services, the next task is to put them into practice -- that is, to change physician behavior to bring about appropriate utilization levels. This task probably will require a combination of education, utilization review and financial incentives.

As a professional society, the College believes that education is the preferable approach to changing physician behavior. Information which is scientifically-based and from a credible source is often sufficient. For example, after we published a Clinical Efficacy Assessment study on the technique called phonocardiography in 1982, an informal audit in the Washington, D.C. area showed that billings dropped from 1400 to 80. Further, there were no retrospective denials in those 80 cases, indicating that physicians learned what constituted the limited, appropriate usage of the technique.

How to conduct these educational campaigns is a critical question. We suggest that the Commission could perform a valuable service by bringing together the research on the impact of educational activities on physicians' practice behavior and how best to do it. We would be happy to contribute our experience in this area.

At some point, if educational efforts fail to bring about appropriate utilization of a particular service, then financial incentives become a tool for controlling over-utilization. The College has argued for a long time that neither outmoded and ineffective procedures, nor procedures inappropriately utilized, should be reimbursed. We suggest that payment denial becomes appropriate where there is a strong consensus on the guidelines for use of a particular procedure. In a sense, the higher the "confidence level" regarding a set of guidelines, the easier it will be to make payment denials and the more support they will have. Obviously, these "confidence levels" will be higher in cases where the guidelines indicate that a procedure is outmoded and simply should never be utilized, than in cases where studies guide the physician to selective use of a procedure with particular patients and under certain circumstances.

We believe that medical specialty societies should identify procedures and services where there is strong consensus on appropriate practices based on data and scientific studies, and should undertake intensive educational campaigns to promote these guidelines and advise physicians on necessary changes in practice patterns. We do not object to Medicare's adoption of those guidelines for utilization review and payment determinations, so long as that is done "with full appreciation that appropriate care depends on the particular clinical needs and preferences of the patient, and that the clinical judgment of the attending physician must be respected" (PPRC report, p. 224). If Medicare uses guidelines developed by the profession in this manner, then good medical practice will be determining payment decisions--and we can support this--as opposed to payment decisions determining medical practice, which we would not support.

EXPENDITURE TARGETS

We understand the philosophy behind the expenditure target proposal, which is to encourage physicians to cooperate and exert peer pressure to achieve appropriate utilization levels. We do not believe that a target or cap is the way to achieve this result.

We have strong reservations about the proposal because the notion of meeting some arbitrary target says nothing about the appropriate level of care. The cap may be set too high, and allow a large amount of inappropriate care that might be eliminated through other mechanisms. Or the cap may be too low, and jeopardize the provision of medical care for patients who need it. It is likely that the cap would influence the practice behavior of those physicians who are already cost-conscious, while it is ignored by those for whom it is most intended. In any case, setting a cap will not assure that services are provided more appropriately.

Medical decisions are made by individual practitioners in individual cases. It is at that level at which efforts to restrain utilization should be focused. Indeed, the physician who is practicing appropriately could be penalized under an expenditure target if the actions of other physicians in the area cause the target to be exceeded. Penalizing that physician, we believe, would be damaging and counter-productive. He or she should be rewarded, and that reward can only happen if the incentives for appropriate utilization, and the focus of assessing utilization, remain at the level of the individual practitioner.

We appreciate this opportunity to appear before you and would be pleased to respond to any questions the Subcommittee members might have.

Thank you.

Chairman STARK. Thank you.

Dr. Austen.

STATEMENT OF W. GERALD AUSTEN, M.D., F.A.C.S., CHAIRMAN, COMMITTEE ON REIMBURSEMENT, AMERICAN COLLEGE OF SURGEONS

Dr. AUSTEN. Thank you very much, Mr. Chairman.

On behalf of the American College of Surgeons, I appreciate this opportunity to appear before the subcommittee to discuss the second annual report of the Physician Payment Review Commission.

The college is aware of the Commission's support for a fee schedule and, in general, endorses a similar change in Medicare's payment approach for physicians' services.

The college's principal concern with the Commission's most recent report is what we believe to be a premature recommendation that any new fee schedule for Medicare be implemented using resource costs as the basis for establishing the relative value of individual physician services. Some of our reservations about this recommendation are conceptual, while others stem from some of the uncertainties about the results that such an approach may yield for patients and for the health care system.

We are disturbed that the Commission endorsed, with so few reservations, the resource-based approach to setting values without waiting for the results from the Government-funded project concerning a resource-based methodology. The results from this project will not be released until later this summer. We would recommend that the members of the subcommittee take note of a minority statement, beginning on page 53 of the Commission's report. This statement was submitted by three of the Commissioners, including the one surgeon member of the panel, to express their view that the Commission does not yet have the benefit of the results of the Harvard project or other information needed to endorse a single methodology for setting relative values.

Unfortunately, some mistakenly view the Harvard project as a scientific and objective assessment of the resource inputs associated with various physician services. But the members of this subcommittee should understand that much of the work is in fact based upon a survey of a relatively small sample of physicians who were asked to estimate time and intensity for a small number of physician services, essentially an arbitrary approach.

The medical profession has had very limited experience with implementation of any resource based RVS. Such a scale, which was designed by a similar Harvard study group a few years ago, was implemented only in Massachusetts with very telling effects on that State's Medicaid program. We urge the subcommittee to examine that experience, which was reported to have been disruptive to patients and physicians alike, by reviewing the report prepared by the Massachusetts Medical Society.

In proposing that resource costs be the primary basis for setting relative values, the Commission asserts that it does not appear practical to use the value of the service to the patient as a basis for setting relative values. Yet, value to the patient seems an important price consideration. For example, patients would be expected to value superior quality services more than those of lesser quality. Similarly, a service of greater diagnostic or therapeutic value to patients generally should be valued more than a less helpful service, even in cases where both services involve the same amount of professional time and other resource costs.

The college takes the position that there is much yet to be done in evaluating the possible use of a resource base relative value scale as the basis for establishing a Medicare fee schedule. We believe defining and measuring value are problematic, raising the need for consideration of alternative ways to establish a fee schedule. Specifically, we believe that actual physician charges also need to be examined and compared with alternative valuation methods in any effort to create a Medicare fee schedule.

Now, setting relative values is only one of the steps required to establish a fee schedule. Determining the amounts by which relative values will be multiplied to establish Medicare fees obviously also is needed. Very little work thus far has been completed in designing indices that will adjust for geographic and justifiable differences in the costs of professional practice. Those of us in the surgical specialties are particularly concerned about the need for any index to reflect the sizable variation in professional liability costs that differ not only from place to place, but from specialty to specialty.

More precise definitions of physician services also are needed. While a common coding system and nomenclature are now in use, the coding services still lack precise or uniform definitions. The college also believes that further attention should be devoted to the development of standardized bundles of physicians' services for payment purposes. We consider the bundling concept to be one of the important ways of addressing current concerns about the volume of physician services and have, up to now, strongly disagreed with the Commission's reluctance to apply the concept equally to nonsurgical services. I was pleased to hear today from Dr. Lee that the Commission is now looking into bundling for office visits and other services.

Chairman STARK. Bundling means if I'm going to have my gallbladder taken out, rather than the hospital DRG and maybe two, three, or four bills, there will be one price.

Dr. AUSTEN. That's correct.

Chairman STARK. They can call that a little gallbladder, if it takes care of the anesthesiologist and the x rays——

Dr. AUSTEN. No. It takes care of whatever the surgeon does.

Chairman STARK. In terms of subsequent followup visits and——

Dr. AUSTEN. You could arrange it in a number of ways; you could start from the time that the patient was seen in the office to make the decision about surgery, all the way through the care delivered by the surgeon in the hospital regarding that cholecystectomy, as well as perhaps the first postop visit.

Chairman STARK. I just wanted to make sure that we were talking about the same thing.

Dr. AUSTEN. And indeed that's the kind of thing that most of us in surgery do now, and a very high proportion of the surgeons do that. But it's not defined as well as it should be.

Mr. Chairman, we share your concern regarding the volume of physician services since volume of services is obviously a key determinant of total Medicare spending. This is true for visit services as well as for procedural services. For example, the volume of visit services depends upon a medical judgment about the frequency of visits necessary to monitor a patient with one or more medical conditions, as well as the number of followup visits that are medically indicated.

However, given the current status of medical practice regarding outcomes of care, we recognize that the relative frequency of visits necessary for each given illness is not well established. Medical monitoring may be the technique necessary to address the question of volume in whatever area of medicine we are talking about. Standards or guidelines will need to be developed in order to compare clinical practice patterns.

The American College of Surgeons continues to believe that a great deal of progress in controlling volume can be achieved through, one, improving the coding system; two, improving service definitions, and three, standardizing the components of care included in a basic service package, such as a surgical bundle.

The college is gratified by the Commission's interest in these issues, and has been pleased to respond to the Commission's request for pertinent information and participation of knowledgeable surgeons on the interspecialty consensus panel being convened to address these matters.

Thank you.

[The statement of Dr. Austen follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

W. Gerald Austen, M.D., F.A.C.S.

RE: Payment of physicians by the Medicare program

May 24, 1988

Mr. Chairman and members of the Subcommittee, I am W. Gerald Austen, M.D., F.A.C.S., a Fellow of the American College of Surgeons, on whose behalf I appear before you today. The College is again most appreciative of the opportunity to present some of its views about the recently issued second annual report of the Physician Payment Review Commission.

The American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality of care for the surgical patient. The College provides extensive educational programs for its 48,000 Fellows and for other surgeons in the United States. In addition, our goals are to promote high standards for surgical practice, disseminate medical knowledge, and provide information to the general public.

The 1988 annual report of the Physician Payment Review Commission reviews many issues relating to reform of Medicare's payment approach for physicians' services. Fellows from the College, including myself, have had the opportunity on several occasions to meet with the Commission and its staff to express our views on a variety of matters under consideration. We welcome these opportunities to provide the perspective of the surgical community.

Fee Schedules and Relative Values

The College is aware of the Commission's support for a fee schedule and, in general, endorses a similar change in Medicare's payment system for physicians' services. We have recommended, however, that any initial steps toward use of a fee schedule under Medicare be selected with care. A stable payment system is an important goal for any significant reform initiative. Efforts should be made, insofar as possible, to avoid unduly sharp adjustments in payment rules or payment levels that might disrupt the continuing availability of high quality physicians' services to Medicare patients. Thus, we urge policymakers to proceed with care in implementing any of the Commission's recommendations about the specific design of a Medicare fee schedule.

Mr. Chairman, the College's principal concern with the Commission's most recent report is with what we believe to be a premature recommendation that any new fee schedule for Medicare be implemented using "resource costs" as the basis for establishing the relative value of individual physicians' services. Some of our reservations about this recommendation are conceptual, while others stem from some of the uncertainties about the results that such an approach may yield for patients and for the health care system.

We were disturbed that the Commission endorsed with so few reservations the resource-based approach to setting values without waiting for the results from the government-funded project concerning a resource-based methodology. The results from this project will not be released until later this summer. We would recommend that the members of the Subcommittee take note of a minority statement beginning on page 53 of the Commission's report. This statement was submitted by three of the Commissioners--including the only surgeon member of the panel--to express their view that the Commission does not yet have the benefit of the results of the Harvard project or other information needed to endorse a single methodology for setting relative values.

Unfortunately, some mistakenly view the Harvard RBRVS project as a scientific and "objective" assessment of the resource inputs associated with various physicians' services. But the members of this Subcommittee should understand that much of the work, in fact, is based upon a survey of a relatively small sample of physicians who were asked to estimate time and intensity for a small number of physicians' services--essentially an arbitrary approach. The approach, in our view, is unproved. It is untried in medicine and untried in any other field.

Relative value scales in themselves will not necessarily save money. Information concerning the multiplier to be used in implementation is needed in order to determine what effect an RBRVS will have on Medicare spending for physicians' services. The intent of the RBRVS is to increase the relative values of nonprocedural services at the expense of procedural services.

The medical profession has had very limited experience with implementation of any RBRVS. Such a scale, which was designed by a similar Harvard study group a few years ago, was implemented only in Massachusetts with very telling effects on that state's Medicaid program. We urge the Subcommittee to examine that experience, which was reported to have been disruptive to patients and physicians alike, by reviewing the report prepared by the Massachusetts Medical Society entitled, "The Application of Resource Based Relative Value Scales to Reform Physicians' Payments: Lessons from the Massachusetts Experience and Concerns Regarding the American Medical Association/Harvard Study."

In proposing that resource costs be the primary basis for setting relative values, the Commission asserts that it does not appear practical to use the value of the service to the patient as a basis for setting relative values. Yet, value to the patient seems an important price consideration. For example, patients would be expected to value superior quality services more than those of lesser quality. Similarly, a service of greater diagnostic or therapeutic value to patients generally should be valued more than a less helpful service, even in cases where both services involve the same amount of professional time and other resource costs.

Thus, the College takes the position that there is much yet to be done in evaluating the use of an RBRVS as the basis for establishing a Medicare fee schedule. We believe defining and measuring value are problematic, raising the need for consideration of alternative ways to establish a fee schedule. Specifically, we believe that actual physician charges also need to be examined and compared with alternative valuation methods in any effort to create a Medicare fee schedule. The Commission itself concludes on page 52 of its report that "charges are nevertheless likely to play a role in the relative value scale."

Other Fee Schedule Issues

Setting relative values, as noted, is only one of the steps required to establish a fee schedule. Determining the amount(s) by which relative values will be multiplied to establish Medicare fees also is needed. Very little work thus far has been completed in designing indices that will adjust for geographic and perhaps other justifiable differences in the costs of professional practice. Those of us in the surgical specialties are particularly concerned about the need for any index to reflect the sizeable variation in professional liability costs that differ not only from place to place but from specialty to specialty as well. We do not believe that this variation is captured adequately in any of the studies being looked at by the Commission's staff or in the Harvard RBRVS project.

More precise definitions of physicians' services also are needed. While a common coding system and nomenclature are now in use, the coded services still lack precise or uniform definitions. Unfortunately, this has complicated the ability to compare payment amounts in one area with those in another, since payment differences simply may reflect differences in the service provided. The College also believes that further attention should be devoted to the development of standardized bundles of physicians' services for payment purposes. Global fees are common in surgery, although, under current policy, each Medicare carrier is free to define the contents of the bundle covered by the global fee (e.g., the amount of postoperative care that is included). We consider the bundling concept to be a viable means of addressing current concerns about the volume of physicians' services and strongly disagree with the Commission's reluctance to apply the concept equally to non-surgical services.

Present policy also permits individual Medicare carriers to set Medicare-allowed charges independently and the resulting geographic variation in Medicare payments for the same service appears irrational. The College, therefore, believes that any effort to reform Medicare's payment approach must rationalize these regional differences.

Volume of Services

Mr. Chairman, we share your concern regarding the volume of physicians' services, since volume of services is obviously a key determinant of total Medicare spending. This is true for visit services as well as for procedural services. In fact, the volume of visit services depends upon a medical judgment about the frequency of visits necessary to monitor a patient with one or more medical conditions, as well as the number of follow-up visits that are medically indicated. However, given the current status of medical practice regarding outcomes of care, we recognize that the relative frequency of visits necessary for each given illness is not well established. Medical monitoring may be the technique necessary to address the question of volume. Standards or guidelines will need to be developed in order to compare clinical practice patterns.

As you know, an RBRVS would do nothing to address concerns about volume issues. In fact, even the Commission appears to be of two minds on the effect of an RBRVS on volume. In one case, the Commission comments as follows ~~with regard to lowering~~ prices: "correcting incentives for overuse created by payment levels significantly above resource costs ... should reduce inappropriate utilization to some degree." In another case, the Commission notes the "possibility that price reductions will be offset by increases in the volume of services." The Commission seems to conclude both that lowering prices may reduce volume and that lowering prices may increase volume.

In contrast, the College continues to believe that a great deal of progress in controlling volume can be achieved through (1) an improved coding system, (2) improved service definitions, and (3) standardizing the components of care included in a basic service package, such as a surgical bundle. The College is gratified by the Commission's interest in these issues and has been pleased to respond to the Commission's request for pertinent information and the participation of knowledgeable surgeons on the interspecialty consensus panel being convened to address these matters.

The American College of Surgeons appreciates your invitation to testify at this hearing, and we continue to stand ready to provide assistance to you and your staff as you examine issues relating to the reform of Medicare's physician payment system.

Thank you.

Chairman **Stark**. Thank you.
Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. **Graham**. Mr. Chairman, Congressman Levin, I appreciate having the opportunity to appear before the committee again, and to discuss the views of the Academy of Family Physicians about the matters which are pending before you.

I would like to say first that we believe that congratulations are again in order to the Physician Payment Review Commission, Dr. Lee and Dr. Ginsburg, for producing yet another report which is thoughtful and substantive, and on time. We feel that this is going a long way toward assuring that the type of debate that we need to have about physician payment reform can take place in a timely fashion.

Mr. Chairman, in your introductory comments, you indicated that you thought there were two principles which had to underlie a review of physician payment. One was the needed access of services for the patients, and the second was cost containment.

I would suggest to you that there is a necessary third principle which we and the committee need to keep in mind, and that is equity of payment for physicians within a given system of reimbursement. Unless that equity is established, or unless it is maintained, the likelihood of physicians continuing to participate in a publicly based program may be diminished, and that is not good in terms of access or the public charges that we are trying to support.

In terms of the PPRC, comments to date and the progress to date with the Harvard study, the academy believes that the Harvard study to date has addressed important issues generally properly. Like the other societies that you have heard from and that you will continue to hear from, we withhold our final judgment on their recommendations until we have a chance to see the final study and to see what the supporting arguments are. But, to date, we feel the study has been looking at the proper issues and has been looking at them in a responsible fashion.

I would highlight just two or three elements of the Commission's report to you that we would like to make comment on. Other elements are discussed in my statement for the record.

We continue to believe, as we have of long standing, that there is no demonstrable basis of logic for specialty differentials. And we believe that any considered revision of physician payment along the relative value schedule should not take into account differentiation by a physician's specialty in setting a fee basis. We believe that similar services should be reimbursed similarly.

At the same time, we believe there is no basis for continuing geographic discrimination in terms of reimbursement and, indeed, such discrimination may be contrary to objectives of public policy. Although data is difficult to come by, it does appear that the cost of practice for physicians in geographically remote communities may be as high or higher than cost of practice for physicians in urban communities. To pay physicians less who practice in rural communities may be counterintuitive to our desire to assure access to services for individuals outside urban areas.

The Commission has suggested to you that there is a possible interim step that the subcommittee should consider, and that is placing a floor under prevailings for primary care services. Although we recognize that there may be difficulties this late in the legislative session for the subcommittee to take this under consideration, we do believe that if the timing and the vehicle is available, that such a floor could be a very important first step to stabilizing some of the continuing disparities between reimbursement for cognitive versus procedural services. That step is something that the committee could do within current authorities and within current law.

Last, in terms of responding to the Commission's report, I would also comment on some of the issues that Dr. Ball has raised about the importance of specialty societies addressing the issue of defining standards and defining clinical guidelines for the practitioners within that specialty. This is an area which we think is important, not only in terms of the physicians' specialties being able to define for themselves what is quality care, it is also going to be an important issue in the public arena as we continue our debate about what should be reimbursed at what level and for what reason, for some of the obvious reasons that Dr. Chassin has raised earlier. The Academy of Family Physicians is currently involved in the initiation of steps that will lead to the definition of, for family physicians, clinical guidelines.

In my closing comments, I would like to refer, not to elements of the committee's report to you, but to some issues which have been raised here earlier here this morning by Dr. Roper and in the followup questions that the panel has had for him.

You have had some extensive discussions about limits. How does one limit the total cost of the Medicare program? And Dr. Roper has pointed out, by their perhaps conservative projections, that within 10 to 15 years, there may be a higher level of public expenditures for the Medicare program than there is for Social Security. I am sure it does not escape the committee's attention that those are two totally different programs, and that's why the rate of increase is different.

Under the Social Security program, a beneficiary knows exactly what they are going to get by a formula. That formula doesn't change based upon that beneficiary's individual circumstances or need. Under the Medicare programs, we have seen a needs based program where there has been a tremendous expansion of services since the program was conceptualized. That is the issue which I believe this subcommittee and which the medical profession are going to have to deal with and struggle with.

You said who shall set limits? We are all going to have to participate in that debate. But I think, in the final analysis, the setting of those limits is going to have to come squarely back to the responsibility of the public representatives. You set this program in motion. Will you be comfortable in setting limits?

At the present time, the Medicare program is limitless in terms of benefits. As we find new mechanisms for epoxy resins to make hip replacements, which may be three times as expensive as the metals that we use now, Medicare will pay for them, just as it has before. As we find new ways to treat cancer that may be twice as expensive, Medicare will pay for them as we have before.

Physician payment is certainly and legitimately a component of total cost of the Medicare program. But when you talk about setting caps, it seems to me you need to keep clearly in mind, based upon the experience of Britain and Canada and the other systems that you may have studied, that when you set a cap, and there are pressure of increasing technology and increasing things you can do for a beneficiary, that one of two things has to give under that cap. You either have to spend less on the beneficiaries or services provided to them, or you pay the providers less.

Chairman **Stark**. Doctor, you left one thing out.

Dr. **Graham**. OK.

Chairman **Stark**. Every doctor who comes here does the same thing. We are always talking about the great benefits of technology and all those new things. But they never give us their increases in productivity.

When it took an ophthalmologist 3 weeks to learn to do the first laser technique maybe he could only do one or two a week, and he got $1,600 and nobody complained. Now that he can do three every morning, and it takes him two afternoons off to miss a couple of golf games to learn to do something, he doesn't give us any of the savings.

All I'm saying is that it's a two-way street. If we're going to have to pay for the higher priced procedures, all I ask is give us some of the cost savings on increased productivity and maybe then we can bargain. But it always goes up and never comes down.

Dr. **Graham**. I think that is a perfectly legitimate point. I fear that the percentage that you will recover by legitimately holding physicians accountable for increasing productivity, which I think is proper, is a much smaller percentage than you would wish.

Chairman **Stark**. I agree. But it would feel better to think I'm getting something back. [Laughter.]

Dr. **Graham**. For a witness to have a chairman who feels well is very important. But the point I am trying to leave you with, as your last witness, to come back around to what Dr. Roper is speaking, and perhaps this is because I represent one of those specialties which is termed primary care, and still one of the few specialties that I know of where the average income of our members is less that of a Congressman, is that I believe that with the best of intentions, we have allowed our Medicare program over the last 20 years to exclude services of access, prevention and primary care at the expense of services of high technology. And yet there is probably no one in this room on your side of the bench or mine, who is willing to look at the beneficiary and says we don't do hip replacements, we don't do dialysis, we don't do organ transplantation, but yet when you come back to Dr. Roper's postulation that we're suddenly going to be bigger here than Social Security, and I think everybody's sense was that's a problem, that shouldn't be, we've got to get a handle on costs. Physician payment as part of that answer, but I believe it's a very small part.

Part of what I believe you will have to deal with as our representatives is the essential contract that we have of enfranchisement and entitlement with this beneficiary population and how much is covered and at what cost.

Thank you, sir.

[The statement of Dr. Graham follows:]

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians, the national medical specialty society representing over 60,000 family physicians, residents and medical students. It is my pleasure to have the opportunity to again appear before this subcommittee to discuss issues relating to reform of physician payment by the Medicare program.

The Academy believes that two goals should govern reform of physician reimbursement: access to quality health care by the American people and equity in payment for physicians. These goals are mutually supportive and should result in a payment system that encourages physicians to provide and patients to seek the care necessary to keep them healthy and active. The Medicare payment system as it has evolved creates barriers to these goals.

SUPPORT FOR RBRVS

I would like to begin by congratulating the Physician Payment Review Commission on its comprehensive March 1988 Report to Congress. The report reflects the thoughtfulness of the many hours of deliberation by the Commission during the past year and makes significant strides toward the development of a framework for Medicare payment reform. In particular, we would highlight the recommendation of the Commission for a relative value scale based primarily on resource costs. This recommendation acknowledges that inherent in the current charge based reimbursement scheme are a myriad of problems that must be avoided if reform is to be achieved. The Academy believes that the resource based approach does have the potential to address many of these problems if implemented carefully.

SINGLE OR MULTIPLE RBRVS

Of principle concern to the Academy is that implementation of a fee schedule result in a single RBRVS for each distinct physician service. However, it is not clear either from the Commission's report, or from preliminary discussion papers by Dr. William Hsiao, that this is the direction being taken by either PPRC or Harvard in their respective work on an RBRVS.

A relative value scale which incorporates differentials by type of specialty practice, by geographic location, or other elements would perpetuate the perverse incentives and inequities in the current system and would defeat the intent of developing a relative ranking of physician services based on resource costs for payment purposes.

We would encourage this subcommittee to be sensitive to the implications of multiple RBRVS for each service as they relate to beneficiary and physician equity, and administrative complexity, during its deliberations about payment reform.

SPECIALTY DIFFERENTIALS

As we have discussed with this subcommittee on many occasions, the Academy strongly supports the elimination of specialty differentials for all physician services. The present payment system allows for different approved charges for similar services based on the use of specialty groupings for establishing prevailing charge limits. The result of this policy is that Medicare approved charges for family physicians are based on different prevailing fees than the charges of other specialists in the same geographic areas providing the same services.

We agree wholeheartedly with the statement in the 1988 PPRC report that "it would be inequitable and illogical to pay one physician more than another for the same service."[1] For this reason, the Academy has for months urged the Health Care Financing Administration to implement nationally the decision of the United States District Court for the Southern District of Michigan concerning specialty based fee screens which concluded, "To the extent that 20 CFR 405.504(b) authorizes the screens set up by the defendants, the regulation is invalid."[2]

On April 12, HCFA did solicit comments on whether and how to modify the policy concerning the use of specialty differentials, specifically whether it should discontinue the establishment of separate prevailing charge screens for physicians services based on specialty practice, with the possible exception of specified medical visits and consultations. We are pleased that HCFA is at last examining this issue, and urge that the specialty differentials be eliminated for all services.

MINIMAL BUDGETARY IMPACT OF SPECIALTY DIFFERENTIAL ELIMINATION

I am particularly pleased to share with you today the preliminary findings of a study by Lewin-ICF on the impact of eliminating specialty differentials under the current Medicare system. Lewin examined the budgetary implications for the Medicare program, as well as the impact on various physician specialists.

Based on the 78 procedures most frequently performed by family physicians in 54 carrier areas, the study concluded that the prevailing charges for family physicians for this set of procedures would increase by 5.03 percent. Lewin also examined the impact on other specialists. General surgeons would increase 3.86 percent, obstetricians 5.5 percent, pediatricians 8 percent and general practitioners 7.02 percent. Those experiencing a possible decrease in prevailing fees for these procedures were general internists (-3.86 percent), general cardiologists (-6.44 percent) and other medical subspecialists (-.21 percent). The approximate financial impact on Medicare Part B payments is an increase of $572,000 or .027 for the sample. [3]

Upon its completion in several weeks, we will submit to this subcommittee the final report prepared by Lewin-ICF. However, we believe this preliminary data is a significant indicator that elimination of specialty differentials will enhance the Medicare program through equity and through greater administrative simplicity, while not further straining the Medicare budget.

We believe that a decision to immediately eliminate specialty differentials will be a positive incremental step toward physician payment reform.

FLOOR ON PREVAILING FEES OF PRIMARY CARE SERVICES

In the discussion of Interim Policy Options, PPRC offers a proposal to place a floor under prevailing charges for primary care services. This is an attractive approach which would address some of the great disparities relating to geographic variation in the short term, and is consistent with action taken by Congress in 1987 to provide a differential update under Medicare for primary care services. We would urge your serious consideration of this proposal.

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[1] Physician Payment Review Commission, Annual Report to Congress, Washington, D.C. (1988): p.87.

[2] Michigan Academy of Family Physicians et.al. v. Blue Cross and Blue Shield of Michigan and Patricia Harris, Secretary of Health and Human Services.

[3] Letter from Judith Arnold, Senior Associate, Lewin/ICF, May 11, 1988.

CODING OF PHYSICIAN SERVICES

In its report, the PPRC discusses the coding of physician services and we believe the commission should continue its examination of this issue. A modification and expansion of visit codes may be reasonable to more accurately describe in greater detail the particular activity which occurs during the visit. However, we would emphasize that codes should reflect the service provided, not the provider of the service.

GEOGRAPHIC DIFFERENTIALS

The Academy believes that a service provided to a Medicare beneficiary in one geographic area is as valuable as when provided in another area. However, current Medicare policy undervalues care provided in rural areas. This urban/rural differential serves as a disincentive for physicians to practice in rural, underserved areas -- and these are the very areas where a greater, and increasing, proportion of the nation's elderly reside. According to the National Rural Health Association 33 percent of the elderly live in rural areas compared with 25 percent of the general population.

Data from Medical Economics[4] show that the cost of providing care in rural areas is higher than in urban areas. Therefore, to provide equity for Medicare beneficiaries and appropriate incentives for physicians to locate in rural areas we would recommend against the application of a geographic multiplier to a RBRVS. The PPRC report shows considerable sensitivity to the particular aspects of physician practice in rural areas. However, we do have some concern that the Harvard study investigators began their deliberations on this issue by considering how a geographical differential can be accomplished. We urge the subcommittee to consider carefully whether continuation of a Medicare geographic differential is appropriate in reform of physician payment, particularly in light of the difficulty experienced by rural hospitals under the prospective payment system.

ASSURANCE OF QUALITY CARE

The Academy has been examining the issue of practice guidelines and their implications for helping to ensure appropriate, quality care for the American people. We are just beginning work on a pilot project to develop clinical policies for patient care in family practice. This pilot phase is expected to continue for two years, and will include an evaluation of the efficacy of such policies for physician education and quality patient care.

CONCLUSION

We commend the Physician Payment Review Commission for the extensive work that it has done to date and look forward to continuing to work with the Commission and with this Subcommittee to achieve a rational Medicare physician payment system.

On behalf of the Academy, I thank you for the invitation to testify before you today, and am pleased to answer any questions at this time.

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[4] Medical Economics, November, 1985.

Chairman STARK. Thank you.

Let me tell you what concerns me, and its mostly the unknown. I've heard it said—certainly not today but by physicians in the administration—that we'll never control costs if the fee-for-service reimbursement system drives the medical delivery system. I don't know whether I agree with that statement or not.

We have a bunch of systems in this country. We've got the military delivery system. I'm incompetent to judge how good or how bad it is, but I participate in it part of the time, and I never hear any complaints, certainly not from the military. And in that system if you're a major, you get a major's pay, and it doesn't matter what kind of a specialist you are, you still get a major's pay. It's probably one of the better socialized medicine systems in the world. Everybody gets the same pay. It's available to everybody. Obviously the waiting period is shortened by rank but, other than that, it works.

There are also HMOs. Some are older and more established, and others are still experimenting, and those go on.

There are some States, like Massachusetts, with some wild and wooly controls put on the system as Massachusetts often leads the way in great social legislation. I don't know whether there's been an exodus since Jerry was last here. I doubt it if three chiropractors and an osteopath have moved to New Hampshire because of mandatory assignment, but maybe they have.

Dr. AUSTEN. They have.

Chairman STARK. They have. OK. [Laughter.]

The simple thing for us to do and the easy thing, and perhaps the cowardly thing is to just say—and it isn't an obsession with things Canadian—look, guys, here's the pie and you all fight among yourselves. At least you'll understand the procedures that were outlined to us previously and know what they mean.

We don't. This committee has been very reluctant to reduce high-priced procedures as we did in the 1987 budget reconciliation. We're just not interested in that.

At some point, if we don't somehow figure out you all as a group and us as a group, we'll get pressured into doing something drastic, because we don't sit here and think, just out of thin air, that we've got to find a way to change the reimbursement system or to save money. We are not necessarily, until we start to hear from my mom and other seniors in the world, saying, my God, my part B premium is going to go up. Part of that pressure is what we've done to them through catastrophic, part of it's your bills. At some point, the pressures will mount, and we won't have done anything, and then we will probably overreact.

The real question is what we ought to do with this relative value study. I think there's going to be winners and losers, and I could probably write the testimony for each specialty once I see the study. It wouldn't be very scientifically accurate, but I bet it would be emotionally and philosophically right down the line depending on whose testimony I was writing.

That doesn't help us. We already know all of that, and you know our problems. Maybe we can go along and let the private insurance companies, the Aetnas and the Blues, establish cost-containment. I don't know the answer.

I think that, there's going to have to be some real bitter acrimonious scrapping within your profession. We see very little peer punishment. Very few physicians have had their licenses yanked by the peer review in their States. It's just a teeny little number compared to, say, the malpractice awards.

So, our instincts, I think, will be to look to aggregate payment because it's politically easy, and we don't have to make any tough technical choices.

I think that, between us, as physicians and purveyors of the public buck, we've got to find a way to make this work. I don't know what it is. I don't think it's just going to be putting a fee schedule on the wall, and saying that's the fee schedule. It seems to me that can be gamed, and we would get bombed down in the same morass we're in now.

I think we will have to be willing to experiment. What would you say Jerry, if I say that Massachusetts must take say 5 percent of $30 billion, let's say we spent 30 billion in part B? I don't know if that's in a year.

So let's say that Massachusetts gets a billion and a half dollars. And then we say, all right, next year we're going to hold that in Massachusetts, to 10 percent. So you're going to get $150 million more dollars than you got last year to provide services.

How would you divvy it up in your State among Medicaid and HMOs and fee-for-service? I think that is what it will come to.

What are the dangers in our doing that, and saying, all right, you negotiate with Governor Dukakis and the Massachusetts Medical Association and stay out of court so we can get this done in time to get your bills paid next year? What would you do?

Dr. AUSTEN. Well, you know I don't know exactly what we would do; however, I think there are a couple of things that I would say. We've got to recognize that what you pay for is what you're going to get. And that is what the beneficiary is going to get. Maybe that's the way to do it, but it is going to result in some problems I think, or it could result in some problems with access.

I think one of the main things it's going to depend on is what we do about the volume issue because I think we could probably handle everything except the increase in volume and increase in intensity issues. And that's something we have absolutely no handle on whatsoever at present.

So I guess what I would recommend is to emphasize the need to figure out some way to control the volume as at least a very major part of the problem.

Many years ago, I spent a year in England, and I saw that system, and I think I know a fair amount about the Canadian system—the way they handle it in Canada and Ontario even though I have not actually spent any time there. And I'm not sure that that's a system, either one, that would be very well received in this country.

There's no question about it, at least in the English one where I was a resident for a year, that that was their way of handling access. I mean there were literally hundreds of patients on my list that had hernias for 2 years, waiting to get into the hospital, as well as many other surgical problems that can cause great trouble.

So you can limit the resources. The question is how to do it in a way that is really fair and does deliver to every American the kind of health care that we want that patient to get? I would be the first one to say that, hearing some of the studies that we've heard, we don't want patients to be subjected to unnecessary services, whether they're surgical or nonsurgical services. And I think we would all agree that there's a certain amount of that going on that we all would like to see terminated.

So we need studies of the type that we've heard about to help us to do that.

Chairman **Stark**. I'm not sure that I think access changes the quality. You could argue that quality and price are inextricably intertwined. But if we deal with the State of Massachusetts or California or any other place, all you really do is cap the income of the physicians. I don't know as that has to lead immediately to—certainly in the short run—less access. It may lead to that, but let's just assume for a minute that everybody does the right thing.

As the Canadians suggest to us, they don't have many superstars. I don't think I'm far off, when I recall what they said, that if our range of physician reimbursement in the United States is 60 to 600,000, they would argue, we say in the same dollars today, that there may be at least 75 more family practice types, and maybe a cap of 200. So they can't hire the guy from Stanford to come to Canada because they don't have that kind of money that he could arguably make here. And they abolish them, but that's the difference in the system as they see it.

I think access may be different, but I think it's there.

Dr. **Austen**. Yes, I think it obviously depends on how it would be set up, and it would depend on what the other insurances were paying, that would be very important.

Chairman **Stark**. That's correct. You're right. If it was all one system, obviously access would still be there.

The question then is——

Dr. **Austen**. And that's what they have in Canada.

Chairman **Stark**. Do we suddenly find that nobody will take Medicare beneficiaries, that they'll only take people in bargaining units who are members of unions or under health insurance? I suspect that wouldn't happen, but you never know.

Dr. **Austen**. One of the other things I would say is that I think we would all agree that the likelihood for a high percentage of physicians accepting assignment is also very much related to what the fee is that the Government pays through Medicare.

Chairman **Stark**. I'm going to turn this over to Mr. Levin here in a minute. And any of you are welcome.

I have a hunch—we've heard reference to our Ways and Means seminars which the public may be highly suspicious of what we do on those weekends when we lock ourselves away from the telephone and constituents and the press, and everything else.

But I have a hunch that the kind of dialog that we have to get down to is, that we have to sit in each other's locker rooms. And I just have a hunch that physicians have to be concerned with their incomes as much as we are. How do we snooker the public into giving us a pay raise so Common Cause doesn't catch us in the process?

I also have a hunch that there is some discussion among physicians about the latest kind of office machines that you can put in, and I don't think that any of them have gotten so aprofessional as to put coin slots in, but I have a hunch that there are procedures that can be done that game the system a little bit. I get through that level of understanding each other's concerns just in a purely economic sense. Then we'll hear some of the debate that you all may have about who are the greedy specialists that you think are either not pulling their oar or are getting too much of the pie, and also perhaps we will find out what kinds of pressures we're getting, both from the right and the left, the seniors groups and others.

And given that interaction for a day or two, I think we could then come back and put on our uniforms and get out in the public view and go at it again, perhaps making a little more progress than we have in the past.

Whether it's purposely mysterious or not, you guys keep everything in there, and don't let us know what goes on, or whether you're just more comfortable that way because you're afraid if we found out, we wouldn't come to see you, I'm not sure just exactly what it is. But somehow there are groups that don't really understand the others' problems in the detail that they ought to. And while attention is good, contention doesn't get us anywhere. I hope we can get further down the pike.

Mr. LEVIN. I very much agree. There are a lot of things we would not agree—all of us in this room—there is a consensus we are getting hungry. [Laughter.]

So I will just be brief. I very much concur in your conclusion. It seems to me that dramatic action is coming. I just do not think we can put it off much longer, and I think that the onset of a new administration—whoever is in it—will be a further opportunity. Opportunity will mesh with necessity, it seems to me, and we just cannot resolve this by $1 billion a year, looking here or looking there.

There is going to be something much more basic than that in the next couple of years. In a word, we may go wholesale or retail—wholesale in the sense to put a cap on it. That is one way to do it.

I myself think that there are some real problems. It is rather easy to say it and not so easy to implement it. But that only puts more pressure on what might be called the retail approach, but if that is going to work, it has to be bold, some bold steps short of just a cap, and saying "You carry it out."

And I must say, as I have reviewed the testimony, in each of your cases, I do not see a lot of boldness. For example, on page 6, Dr. Austen, where you describe your remedy, the medicine does not have a lot of bite in it, it seems to me.

"A great deal of progress in controlling Valium can be achieved through three steps: an encoding system, improved service definitions." I do not think you will persuade very many people that we are going to get very far—maybe somewhere, but not very far.

I do not mean that too critically, because it easy to analyze and much more difficult to prescribe here.

In the American College of Physicians' kind of summary on page 8—I think we need very much to know what it really means. I must confess, when you talk about "identified procedures and services where there is a strong consensus on appropriate practices based on data," et cetera—"We do not object to Medicare's adoption of those guidelines for utilization review and payment determinations, so long as that is done with full appreciation that appropriate care depends the on particular clinical needs and preferences of the patient, and that the clinical judgment of the attending physician must be respected."

I do not know what that translates into in terms of a system, and that is the real task I think of the next year or two. We must come up with a new system. The status quo just will not work, payment on a fee basis.

In terms of Dr. Graham's statement on access, I will just give you my own very tentative judgment, because I think what Pete Stark said is so true. I do not know about the locker room, but getting into each other's shoes.

It is easy to say we have to limit access, but very difficult to carry out in terms of hip transplants. I think what we did in terms of dialysis was right.

In this country, I think we are not going to deny it, and the same is true of hip transplants. We are not going to do a very adequate job of denying access to a lot of procedures.

When some people are giving their pets hip transplants in America, I do not see our denying hip transplants to senior citizens. I just do not see it.

That does not mean that we will pay for everything, but I think it is going to be very difficult to control costs by dramatically limiting access.

So in brief, that is kind of where one member is today. I think this has been a useful kickoff, I guess for the second or third time, and no one expects we will be even at the 10-yard line, regardless of the locker room.

But I think by this time, maybe even before this time next year, Mr. Chairman, we are going to have to be far beyond the 10-yard line.

Chairman **STARK**. You all have waited. Do you want to have the last word?

Dr. **BALL**. I'd like to take up the challenge.

Chairman **STARK**. Go right ahead. That is fine.

Dr. **BALL**. I'd like to take up the challenge of Congressman Levin as far as a bolder approach, and it comes from a history of some dozen years working with Blue Cross and Blue Shield, trying to eliminate inappropriate practices, and trying thereby to assure that there is some reimbursement for appropriate practices.

Over the last dozen years, we have come up with recommendations for 200 procedures in internal medicine, which Blue Cross and Blue Shield have instituted in our joint medical necessity project. The Blues will not pay for those things that we have determined are inappropriate, and will continue to pay where appropriate indications that have been determined by us do in fact exist.

To me, that is a way of getting what I think we are all interested in—society, patients, Congress, HCFA, and we in the medical profession—which is to stop paying for services that are inappropriate, as determined by medicine, and to start paying for services at an appropriate level, that are appropriate as determined by medicine.

And we proposed with the medical profession, with HCFA, a partnership of doing two things: one is the medical profession working to come up with standards of what appropriate medical care is, and the seond is working with the payers, as we have in the past worked with Blue Cross/Blue Shield, but to begin now to work with HCFA to come up with appropriate payment levels for those services.

We see the Harvard RVS as the piece that looks at appropriate payment levels, and we see the medical profession as having to take up the responsibility of coming up with standards for what appropriate care is.

And then, instead of throwing up our hands, and surrendering to cost, we can help assure the other two components of health policy, which are quality and access for people.

Dr. **Graham**. Let me take one last pass at some of your comments, and Congressman Levin's comments.

I guess what I am trying to suggest is that is as important as this near-term issue of physician payment reform is to us, there are larger issues to be dealt with.

Let's assume it gets done, and something happens. It is fixed. And whether that is the Canadian system and we now have nobody paid less than 75,000 and nobody more than 300,000, or whatever the outcome—it is fixed.

My suggestion to you, in the context of Dr. Roper's comments earlier this morning, is that that will not substantially change 2015. That it will not substantially change the aggregate cost to the Medicare program of the undefined entitlement that we have today for our senior citizens.

And I am not arguing rationing. I am not arguing that we ought to do something bad. I am simply saying that that is a public policy issue which faces us as representatives and as the profession.

Dr. Roper would prefer not to resolve that. He wants capitation. You would prefer not to resolve it. You'd like to have the States negotiate everything under a cap.

You made passing reference to Mr. Califano. Mr. Califano is going about trying to resolve that in a way which is not consistent with the policy of the committee thus far, and that is, he's charging the beneficiaries more.

That is part of the revision of the Chrysler plan. What I am suggesting to you is that although physician payment reform is very important, and it is what we were called here to talk about today, there are other major issues.

The discussion got broadened by Dr. Roper's introduction, and I think appropriately so. Physician payment reform is very important. It is overdue. It needs to be done; it needs to be done correctly.

Once it is done we all still face a much larger issue of how to appropriately define in the public interest this entitlement.

Mr. Chairman, I would simply close my remarks by referring back to your locker room analogy. I had the opportunity to appear before you 18 months ago, and I did indeed invite you into the locker room of some of our members. You went to Canada instead.

I would reextend that invitation with great sincerity. We would be happy to make arrangements for you to spend some time with practicing family physicians, to get a sense of the issues, the way they see it in their offices day in and day out—not in an adversarial way, but exactly in the spirit that you offered it. Perhaps you would invite them into the committee hearings for a couple of days, so that we can understand the issues, the way each of us sees it.

Thank you.

Chairman **Stark**. I think you have touched on a point. I appreciate the invitation, and as I say, there is certainly not any prejudice—our visit to Canada was coincidental to this.

But while you are talking about physician reimbursement, that may send up signals of alarm among the physician community—and Dr. Roper, you quite rightfully interpret the administration's interest in capitation as an alternative, and Califano's idea that everybody give a little, including the physicians in the hospitals.

So ours is primarily a question of cost, and containing the growth of this cost. I think the entitlement is a given.

Some of my colleagues may, philosophically, and politically, not accept that we really ought to restrict the growth of how broad the entitlement is.

We are going to get into that discussion in long-term care, which basically is not a medical problem as much as it is an income problem.

It may not be that physician reimbursement makes a whole hell of a lot of difference. I am not sure what would happen if we said that no physician in this country could earn more than $200,000, period.

I do not know what would happen to part B, it might go up, it might not. Looking at dialysis, I am sure that we are paying too much. Some people are taking in $200,000 and $300,000 salaries a year—husband and wife teams on a dialysis operation, and we are paying the whole bill—something is wrong with that system.

I mean, the Government ought to be getting better bids. I do not know whether the best idea is to build a dialysis center and say that this is the model, and this is the way it ought to be on every street corner, or whether you guys ought to come back to us and set the standards, and say, in addition to what you ought to receive in fees, maybe you ought to bundle up the dialysis, and say to any American who is receiving dialysis that it is going to cost you no more than *x* dollars.

Sooner or later we may get pushed into those discussions, and I think if we do it together, the parts have a lot of different interest in them.

Ours is a simple interest, where there is really not much concern, between whether the surgeons are making more money than the family practitioners.

We may have our prejudices, but the politics of that division does not impact us very much, certainly not as much as the AARP, and whether we are going to give them free pharmaceuticals or not.

I mean, we need more of this, and I think we have to look at the Canadian system, the military system, the HMO system, and the fee-for-service system, because as Sandy indicates, something's going to change, and we have seen changes come around here. We really have no control. I mean, all of a sudden we find that the train has left the station and is so far down the track that, as a politician, you just vote okay and hold your nose.

Do you want to have the last word?

Dr. **Austen**. All right. A couple of things. One is, I would just reemphasize the point about volume, in my view, being perhaps, the key issue here. The other thing I would say, is that whatever we do in terms of reform of physician reimbursement, in my opinion it needs to be done very carefully, and in a way that does not impact on access of care to the beneficiary.

And if it is done too abruptly, it is going to be very hard not to impact very unfavorably on the patient, I think.

Chairman **Stark**. I think that the abruptness of any change is something that concerns us. Certainly we have heard it from everybody who is party to this debate, that you are not going to change this overnight.

But that if we do not—we, collectively—make some changes it is going to come at us from some other source, and we may be in a worse mess.

I want to thank you all for helping us. I hope you will not wait to be called. I mean, we would love to have you volunteer your comments at any time. We appreciate it. The committee stands adjourned.

[Whereupon, at 1:26 p.m, the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN ACADEMY OF OPHTHALMOLOGY
AND NINE OPHTHALMOLOGICAL SUB-SPECIALTY ORGANIZATIONS

TESTIMONY BEFORE
THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

MAY 24, 1988

This testimony is being presented on behalf of the American Academy of Ophthalmology and the nine ophthalmological sub-specialty organizations, whose names are listed at the end of this testimony. The Academy's membership, alone, represents more than 16,000 ophthalmologists, which is 96% of the ophthalmologists in the United States. Together, our ten organizations represent all of American organized ophthalmology.

We recognize that the current system of Medicare reimbursement is flawed and agree that thoughtful reforms are needed. We continue to offer our services and expertise to those interested in achieving such reforms.

We have several thoughts about developing and using a RVS-based fee schedule for physician services under Part B of Medicare. One particular approach to a relative-value scale (RVS) is nearing completion at Harvard University under the direction of William Hsiao, Ph.D. The final report from those scientific researchers is due to be delivered to the Health Care Financing Administration (HCFA) in mid-July, which is expected to release it to the public a month later.

Ophthalmologists are concerned that they and other physicians have not been allowed to participate in the Harvard RVS project during the vital period when the project's assumptions were being established. Nevertheless, ophthalmologists did cooperate up to the limited extent permitted by the Harvard project staff. There is a fundamental and critical difference between active participation and reactive cooperation.

THE LACK OF ACTIVE PHYSICIAN PARTICIPATION IN *ALL* PARTS OF THE PROJECT MAY RESULT IN IT BEING NOTHING MORE THAN AN ABSTRUSE ACADEMIC EXERCISE HAVING LITTLE PRACTICA VALUE FOR THE MEDICARE PROGRAM OR FOR FEDERAL DEFICIT REDUCTION.

Since we have not yet had the opportunity to review Dr. Hsiao's full report, our remarks in this testimony will be confined to the general issue of using any RVS for physician reimbursement policy.

Our testimony will stress these points:

- Every relative-value scale primarily mirrors the researcher's assumptions and selection of VALUES for measurement, which may affect the resulting scale even more than data quality and analytical soundness.

- Use of a RVS-derived fee schedule would merely re-allocate the same amount of reimbursement funds among the same number of physicians; it would not reduce Medicare expenditures.

- Before basing public policy on a particular RVS, there must be debate and agreement on the assumptions and values, as well as the data and analysis.

- When the Harvard resource-based RVS is completed this July, the researchers' assumptions and values must be scrutinized and the data and analysis evaluated.

Ophthalmologists understand the Government's need and resolve to contain the cost of physician services under Medicare within reasonable limits. We also understand the Government's need to be sure that America's older citizens have access to the medical services they require and receive the same quality of care as other Americans.

First, EVERY RELATIVE-VALUE SCALE (RVS) PRIMARILY MIRRORS THE RESEARCHER'S ASSUMPTIONS AND SELECTION OF VALUES FOR MEASUREMENT. THOSE FACTORS MAY PROFOUNDLY AFFECT THE RESULTING SCALE--EVEN MORE THAN THE QUALITY OF THE DATA AND THE SOUNDNESS OF THE ANALYSIS.

In developing a RVS for physicians the researcher must start with assumptions about why the scale is needed, how it would be used, and what it should measure. The decisions at this point are fundamental to the outcome.

For example, two researchers could each seek to establish a SOCIAL-BASED RVS. The first researcher could assume that the benefit of a procedure or service to society is best judged by the increase on the patient's life-span. He might choose to identify post-surgical factors suggesting increased longevity. He would collect descriptive data concerning those factors and the medical procedures and services. He would analyze that data and produce his relative-value scale.

The second researcher could assume that the social benefit is best judged by the increase in the patient's quality of life. This researcher may not be concerned with longevity; instead, he would choose factors suggesting improved mobility and independence. He would collect his different data, perform a different analysis, and produce a different relative-value scale.

In this example, both researchers had the same assignment--to develop a social-based RVS. We can assume both researchers also completed their projects competently. Yet, each resulting RVS would be fundamentally different from the other.

Such differences are inherent in any RVS, and they will certainly exist in any resource-based RVS. For example, if the length of residency program is considered a more significant resource than the years of medical practice, then a different RVS would result. How does the choice of assumptions affect the resulting RVS? Which assumption is correct? Should one factor be included and the other not?

When a particular resource is included, further problems arise. For example, different ophthalmologists have very different practice costs. The amount of sophisticated medical equipment in an ophthalmologist's office depends on the nature of his own individual practice. Ophthalmic surgery is performed within microscopic dimensions. For ophthalmologists, the use of very expensive state-of-the-art equipment in the office makes a real and profound difference in the access to care and the quality of care for Medicare beneficiaries. The miracle of modern cataract surgery illustrates this point. In devising a resource-based RVS, the question becomes exactly how should practice costs be measured?

Thus, ophthalmologists emphasize that a RVS primarily mirrors the researcher's assumptions and selection of values for measurement--factors that will profoundly affect the resulting scale. These are the factors that determine what the RVS will be.

It is for these reasons that we are concerned that physicians were excluded from actively participating in the Harvard RVS project during the critical period when the project's assumptions were being established.

Second, USE OF A RVS-DERIVED FEE SCHEDULE WOULD NOT REDUCE MEDICARE EXPENDITURES. IT WOULD MERELY RE-ALLOCATE THE SAME AMOUNT OF REIMBURSEMENT FUNDS AMONG THE SAME NUMBER OF PHYSICIANS.

The two key Medicare expenditure issues are the price of individual services and procedures and the frequency of utilization. Under a RVS-based fee schedule, the fees of some physicians would be reduced, and those of others would be increased. Yet, the total dollars expended by the Government would remain at about the same level. In other words, the physician reimbursement

PIE would be sliced differently, but its size would remain the same.

A RVS-based fee schedule would have no direct affect on utilization. However, a poorly-conceived fee schedule could produce unexpected results that could indirectly lead to increased utilization. The Part B costs of the Medicare program would increase. PPRC expressed concern about this prospect in its March 1988 Annual Report to the Congress.

We do not believe that a fee schedule should be advocated to physicians or to the public as an economy measure, if it would not actually reduce expenditures without resorting to additional measures. In fact, use of a fee schedule would be budget neutral.

Third, BEFORE BASING PUBLIC POLICY ON A PARTICULAR RVS, THERE MUST BE UNDERSTANDING, DEBATE, AND AGREEMENT ON THE ASSUMPTIONS AND VALUES, AS WELL AS THE DATA AND ANALYSIS.

Setting a physician fee schedule is a matter of public policy. All of the major ideas and components involved should be publicly identified. They should be openly discussed and debated. A consensus should be reached. The proposal should be modified accordingly. Then--and only then--should Congress and the Administration move forward. The reason for adhering to this process is basic to our government. An uncertain and unintended result must be avoided.

As an illustration, recall the example used earlier. Each of the two researchers was given the same assignment, and each completed his project proficiently. Yet, the two researchers produced radically different RVSs. Consequently, a fee schedule based on either of these two RVSs would be different. Thus, no matter how competent the researcher, his instructions must be narrowed. In this example, he should have been asked to develop a social-based RVS using very specific assumptions and values.

If a fee schedule were established based on inappropriate ideas and unsuitable information, the direct result--the physicians' fees--would be substantially in error. Some physicians might not be able to continue their present levels of investment in office medical equipment and personal training. This situation could lead to the quality of and access to care for Medicare beneficiaries being unintentionally affected.

Clearly, the assumptions and values underlying any RVS are fundamental to the resulting policy. They must be determined in public.

Fourth, WHEN COMPLETED THIS JULY, THE ASSUMPTIONS AND VALUES UNDERLYING THE HARVARD RESOURCE-BASED RVS MUST BE SCRUTINIZED. THIS REQUIREMENT IS IN ADDITION TO THE NEED TO EVALUATE THE DATA AND HOW IT WAS ANALYZED.

We understand that both HCFA and PPRC intend to evaluate the Harvard report in depth. We emphasize that their evaluations must extend to the underlying assumptions and values in addition to the methodology, the data and its collection, the resulting RBRVS, and the conclusions. For instance, these evaluations must include the following aspects:

- o What assumptions and values were used?
- o How sensitive is the resulting RVS to variations in the assumptions? To variations in the values?
- o What is the quality of the data? How much statistical error is present in the data?
- o How sound is the analysis? Is any statistical error introduced by the analysis?
- o How does the mathematical algorithm compare with those used for other clients and by other researchers?
- o Is the mathematical algorithm complete and appropriate? Were significant factors omitted or insignificant ones included? (Viz: patient condition; physician ability; etc.).
- o How sensitive is the resulting RVS to variations in the mathematical algorithm?
- o Are the conclusions of the Harvard project fully supported by the underlying research?

Before a RVS is allowed any role in Federal physician reimbursement policy, the proposal must be understood fully by the policy makers, the affected parties, and the public. They must understand how its assumptions and choice of variables affect the resulting RVS, and they must have a credible opportunity to affect those decisions. This is not the situation with respect to the Harvard RVS.

Any RVS that is implemented, moreover, must reflect all the factors that have traditionally determined the value of services in our country. Thus, the RVS must account for the value accorded a particular service by the marketplace, for the impact of the procedure on patient outcomes and quality of life, and for patient preferences about their own medical care. In addition, we must be certain that physician's choices as to medical care are not skewed by any RVS that is adopted. Quality of care must not be subordinated to the need for short-term solutions to the problems of rising costs.

Mr. Chairman, our ten organizations again thank you for this opportunity to voice the comments of organized ophthalmology. We look forward to working with you and your staff.

THE AMERICAN ACADEMY OF OPHTHALMOLOGY
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
CASTROVIEJO SOCIETY
MACULA SOCIETY
RETINA SOCIETY
AMERICAN GLAUCOMA SOCIETY
AMERICAN ASSOCIATION FOR PEDIATRIC OPHTHALMOLOGY AND STRABISMUS
AMERICAN ASSOCIATION OF OPHTHALMOLOGIC PATHOLOGISTS
AMERICAN SOCIETY OF OPHTHALMOLOGIC PLASTIC AND RECONSTRUCTIVE SURGERY
CONTACT LENS ASSOCIATION OF OPHTHALMOLOGISTS

STATEMENT OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SUBCOMMITTEE ON HEALTH, WAYS AND MEANS COMMITTEE
FOR THE RECORD ON PAYMENT OF PHYSICIANS
BY THE MEDICARE PROGRAM

MAY 24, 1988

Introduction

The American Society of Internal Medicine (ASIM) appreciates the opportunity to express the views of internists throughout the country on alternative payment methods for physician services under the Medicare program.

In the years since ASIM was founded in 1956, the Society has played a leading role within the medical profession in studying and formulating innovative approaches to paying for physician services. During the past eight years in particular, the Society has devoted considerable time and resources to identify the problems in the current system of payment for physician services—and developing constructive proposals to address and resolve those problems. In this process, ASIM has developed specific objectives and principles on payment for physician services that can serve as a basis for legislation to alter the current system of payment under the Medicare program.

Congress has demonstrated its support for efforts to enhance payment for traditionally undervalued primary care services, most recently through passage of legislation that increased Medicare payments selectively for primary-care services to a greater degree than all others. Congress also recognized the important contribution of the results of the Harvard resource based relative scale, now under development, to physician payment reform, by including in the Omnibus Budget Reconciliation Act (OBRA) of 1986 provisions that delay until January 1989 the requirement that the Secretary develop a relative value scale as a basis for payment under Medicare (thus allowing for completion of the Harvard project.) Moreover, in OBRA 1987 Congress required the Department of Health and Human Services to submit by July 1989 a study of changes in the payment system for physicians' services that will be required for the implementation of a national fee schedule by January 1990. Similarly, the Physician Payment Review Commission, charged with the important task of recommending changes in Medicare's system of paying physicians, has for the second consecutive year endorsed measures to improve payments for undervalued cognitive or primary care services.

This statement will focus primarily on ASIM's response to the recommendations on physician payment contained in the Physician Payment Review Commission's (PPRC) second annual report to Congress.

Report of the Physician Payment Review Commission

ASIM believes that the recommendations and analysis contained in the Commission's second report to Congress deserve serious consideration by the Subcommittee. The Commission has done an admirable job of translating the goals for physician payment policy it identified in its first report to Congress, into viable options for short-and-long-term reform. While much remains to be accomplished in the coming year, the Commission is well on the way to achieving rational solutions to the problems facing the physician payment system under Medicare. ASIM generally supports the direction the Commission is taking and has the following specific comments on areas addressed in the report.

Fee Schedules

ASIM strongly supports the Commission's recommendation that a national Medicare fee schedule be established based primarily on resource costs. In endorsing a resource-cost relative value scale, the Commission specifically rejected an RVS based on historical charges, arguing that "the current pattern of relative charges is likely to be distorted" and noting that "the desire to depart from current patterns of relative values is the principal reason" for its endorsement of a resource-based RVS. ASIM agrees with the Commission's analysis of why historical charging patterns have been distorted by the health insurance market:

> "Historically, [insurance] has covered surgery more extensively than medical services. In some plans, surgery is the only physician service covered. The use of deductibles has contributed to this orientation because a higher proportion of small bills (mostly for primary care) are not reimbursed. A patient seeking primary care knows that in many instances the entire bill will have to be paid out-of-pocket, while a patient seeking surgery expects that insurance will pay most of the bill. As a result, patients tend to be more sensitive to the price of primary care than of surgery, and this affects relative prices. While Medicare's coverage of physicians' services is less uneven than that of many private plans, the charges that are the basis of its CPR payment are affected by the overall pattern of insurance coverage."

For years, ASIM has argued for the development and implementation of a resource cost based schedule of allowances as a basis of payment under Medicare. Such a system would correct the historical distortions cited by the Commission in its report. By developing a relative value scale based on resource costs--which in turn would be used to construct a schedule of allowances by the inclusion of appropriate dollar conversion factors--Medicare for the first time would have a relatively simple, understandable, and predictable system that would reduce the distortions in the relative values of cognitive and procedural services. A resource cost payment system--by placing more reward on time consuming, complex "cognitive services" in comparison to technical procedures--would be a major step toward reducing incentives for over utilization of high-cost technology, thus making fee-for-service under Medicare a far more cost effective payment option than is now the case.

ASIM is pleased that the Commission is giving prominent attention to the work of Professor Hsiao of Harvard University, and appreciates the need for the Commission to carefully evaluate the Harvard RVS. The ultimate credibility of that effort, ASIM believes, will be enhanced by an open and candid discussion of its merits. We believe that the Commission can play a very useful role in promoting such discussion and specifically endorse the use of public hearings to receive comments on the project.

ASIM has some concerns, however, over the Commission's stated intention to consider other methods for estimating resource costs, including resurveying physicians and/or convening consensus panels to "address possible limitations in methodology." We have urged the Commission to exercise caution in allowing the Harvard results to be substantially revised through consensus panels, a process that is likely to be a less scientific approach to establishing relative values. As a consequence, a revised RVS based primarily on the work of consensus panels--which will be composed of far fewer physicians than participated in the Harvard study--is likely to be less acceptable to to physicians, beneficiaries, policymakers and others. Moreover, consensus panels must not become the vehicle by which individuals who are more interested in maintaining the status quo than achieving equity attempt to "refine" the study to the point where the "refinements" are so extensive that the RVS ends up echoing patterns in the existing charge-based system.

ASIM cautions Congress not to prejudge the Harvard project before the results are released based on claims by critics of the study that the methodology is unsound. Although it is proper to have an open discussion and constructive debate on the appropriateness of the Harvard methodology and its conclusions, such debate should not become a vehicle for delaying or blocking fundamental change in the payment system. Discussion should focus not only on narrow technical issues, but more appropriately on the broader philosophical issue of whether inequities in the Medicare physician payment system should be redressed by replacing Medicare CPR with a schedule of allowances based on resource costs.

Specialty Differentials

ASIM is aware of the Health Care Financing Administration's request for comments on whether to discontinue the establishment of separate prevailing charge screens for physicians' services based on specialty practice. We are in the process of reviewing the Federal Register announcement and will be happy to share our comments with the Subcommittee when they are available.

Generally, our position at this time is that the issue of specialty differentials should be addressed in the overall context of the development of a resource-based relative value scale. PPRC in its report indicates that it will begin developing a uniform national policy for specialty differentials under a fee schedule. Therefore, ASIM believes that it would be premature for HCFA to make any changes in its current policy before it has the benefit of PPRC's analysis, which will involve consultation with outside groups and more indepth study than HCFA could devote. As PPRC notes, "...any change in policy for specialty differentials before implementation of a fee schedule would impose substantial administrative costs on carriers and physicians, and its effects on access, cost, and quality would be difficult to predict."

ASIM also believes that to the extent that the resource costs involved in providing a service differ according to the training ~~of a physician~~, those differences should be recognized by placing an appropriate relative value on the specific service billed by that physician, rather than by specialty differentials for all services. This view is largely consistent with the Commission's approach which argues for improving definitions of existing codes or developing a new set of codes to account for differences in work by specialty, resorting to specialty differentials in payments only if coding reform turns out not to be a feasible solution.

Assignment and Participation: Policy Options

The Commission outlines various options to encourage improved acceptance of assignment--educating beneficiaries on the "advantages" of seeking out participating physicians, "all-or nothing assignment", limiting balance billing for selected services--but does not make specific recommendations. ASIM is concerned, however, that the strategies outlined by the Commission seem more directed to encouraging patients to select physicians who will accept assignment on all claims or making it far more difficult for physicians to decline to become participating physicians, rather than to improving the overall acceptance of assignment.

ASIM continues to believe that a more appropriate policy objective is to assure that those patients in financial need are appropriately taken care of (either through reduced fees or acceptance of assignment), rather than attempting to force physicians into accepting assignment for all patients. Improvements in the payment levels for various services (particularly for undervalued cognitive services), encouragement of voluntary programs by which physicians agree to accept assignment or reduce fees for those patients in need, improving Medicare billing procedures so that all physicians have a greater incentive to accept assignment, improving the dissemination of information on fees and assignment policies so that patients know in advance whether or not a physician will accept assignment and the difference (if any) that he or she may be responsible for paying out-of-pocket, and other strategies designed to target those patients most in need all merit consideration.

Unfortunately, most of the strategies outlined by the Commission fail to target those patients most in need or to provide sufficient flexibility for physicians and patients to negotiate payment arrangements that do not involve acceptance of Medicare assignment. While acceptance of assignment may appear to reduce beneficiary out-of-pocket expenses (which may not be necessarily true if the volume of services and the required copayment is increased as overall cost-sharing per service diminishes), it may do so at the price of reduced access to necessary services and a weakening of the doctor-patient relationship.

ASIM believes that the evidence clearly shows that physicians are willing to accept assignment or discount fees to Medicare's "approved amount" for patients in need. ASIM's own "Personal Care" program, under which enrolled physicians agree to several measures to improve the predictability of the Medicare assignment option (including publicizing the fact that they will accept assignment or reduce fees to Medicare's "approved amount" for all patients in financial need, issuing identification cards to specific patients that require special financial arrangements for an extended period of time, assisting in the filing of all claims for Medicare patients, and discussing fees and assignment policies in advance of rendering services) has received widespread acceptance within the medical community. Three state medical societies--the South Carolina Medical Association, the Colorado Medical Society, and the Medical Society of the District of Columbia--all have agreed to co-sponsor "Personal Care" in their own states. In just a few weeks, over 800 physicians have enrolled in "Personal Care" in South Carolina (representing almost 1/4 of all non-participating physicians in the states) and 500 have enrolled in the Colorado "Personal Care" program. All together, close to 2,000 physicians have joined the "Personal Care" program. Other state and specialty societies are exploring the possibility of co-sponsoring ASIM's "Personal Care" program for their own members, which should substantially increase overall enrollment. These and other voluntary programs to assist patients in financial need clearly demonstrate that physicians are willing to take appropriate action to help those patients who have difficulty affording their medical bills.

ASIM believes that Congress and the Commission should explore strategies that build upon this record, rather than promoting far more coercive (and disruptive) approaches to the balance billing issue.

Expenditure Targets

ASIM has serious concerns about the conclusions reached by the Commission on expenditure targets, namely that "expenditure targets are a potentially promising means of addressing the problem of rapidly rising volume of services." In its report, the Commission fails to address what ASIM considers to be the most significant disadvantage of this approach: the clear potential that expenditure targets will result in underprovision of needed services, thereby having a serious detrimental effect on the quality of medical care provided to Medicare patients. The most glaring example of this is in the United Kingdom, where subsidized care such as dialysis is denied for entire classes of people such as those over 55 years of age.

The basic problem with the expenditure target approach is that it imposes a predetermined decision on the amount of resources to be devoted to medical care on the ability of individual physicians to provide their patients with appropriate care. By placing all physicians at "risk" for services provided to their patients, a clear incentive exists for physicians to "do as little as possible" to stay within the expenditure target. Once an expenditure target is exceeded, payment levels over time would either be reduced immediately, or would be given little or no increase the following year. Once this occurs, it is quite conceivable that payment levels would be so constrained for many services that physicians would no longer be able to provide certain services to their patients. Both these effects could seriously diminish the quality of care provided to Medicare patients. It is ironic that given the growing congressional concern over existing Medicare risk arrangements that may be adversely affecting patient care, the Commission now is looking favorably at placing all care provided to Medicare beneficiaries under a risk arrangement.

Second, since no one knows how to define an appropriate aggregate volume of services to be provided to beneficiaries, it is impossible at this time to even conceive of establishing an expenditure target that would be appropriate and realistic. Using adjusted per capita utilization at the U.S. average, for example, suggests that the "average" is the "appropriate" level of utilization, when in fact higher (or lower) than average utilization could represent the most appropriate care. Targets that involve restraints on the rate of increase, on the other hand, might constrain growth and services below what is appropriate for continued advancement in patient care. No matter how the initial expenditure targets are established, there is a clear danger that an administration or Congress that wishes to reduce federal expenditures on medical care would set expenditure targets that will save money--but at the price of reducing access to needed services.

Third, expenditure targets raise an equal protection issue. Beneficiaries who happen to live in a locality whose expenditure target has been exceeded may find that their access to care is subsequently reduced if physician find that they are no longer able to provide essential services at the lower payment levels, while patients in other areas that have not exceeded the cap may have access to more and (better) services.

Fourth, this concept grossly exaggerates the ability of physicians to control the practice patterns of their peers. Unlike an HMO or other contractual managed care system where physicians individually agree to abide by utilization controls as a condition of fulfilling their contractual obligations to the plan, there is no parallel mechanism for exerting influence across boundaries as large as a state. Indeed, antitrust statutes would be likely to preclude physicians from taking collective action to sanction a peer who is suspected of "overutilizing" services. Moreover, physicians who practice a prudent style of medical care would be penalized if their state exceeded the expenditure target to the same degree as physicians who are "overutilizers." This hardly creates a rational incentive for individual physicians to change their own practice patterns.

Fifth, unless the expenditure target applied to all payors, Medicare patients might ultimately find that they are discriminated against. Since Medicare patients would be the only ones whose care would be subject to an overall cap on expenditures, physicians may over time begin treating those patients differently (and not as well) as private patients.

For these reasons, ASIM urges Congress to proceed cautiously in evaluating the feasibility of expenditure targets for the Medicare program. Careful study of this approach and its implications for patient care must be undertaken before any quick conclusion is reached that this is a desirable way of controlling volume.

Increasing Appropriate Use of Services: Practice Guidelines and Feedback of Practice Patterns.

ASIM agrees with the Commission that "carefully developed [practice] guidelines can play a highly constructive role in the Medicare program." We concur that "both the process through which guidelines are developed and the ways they are applied must recognize the unavoidable uncertainty in medical knowledge and the essential role the attending physicians' clinical judgment must play in medical practice." This underscores the importance of assuring that medical organizations which have credibility with practicing physicians be involved in developing the guidelines. Physicians who are in day-to-day contact with patients, for example, may very well have a different perspective on treatment protocols than those physicians that are involved primarily in teaching.

ASIM supports the Commission's intent to convene a conference to develop a strategy to develop practice guidelines, and welcomes the opportunity to participate in this important project.

Improving Utilization Review in Medicare

ASIM supports the Commission's call for more intensive research and development efforts in the whole area of medical review. We believe that utilization review by Medicare carriers and peer review organizations can play an important role in reducing unnecessary volume of services provided that such review programs are implemented fairly and reasonably and in a manner that is the least intrusive as possible but is effective. As the Commission points out, "beneficiaries and providers frequently have problems getting prompt and understandable answers to questions and communications with physicians about local utilization review processes and problems are very limited."

The findings of ASIM's 1987 Carrier Accountability Monitoring Project (CAMP) survey bear this out. (Questionnaires for this survey were mailed to a representative sample of ASIM members throughout the country in July 1987. A systematic selection process was used to select every nth name from ASIM's membership files. The data in this survey are based on the results of 763 completed questionnaires.) The survey results strongly suggest that there is a "crisis in confidence" in existing Medicare utilization review procedures. Fully 71 percent of ASIM members agreed with the statement "Medicare is requiring more unnecessary documentation for claims to be paid." Sixty-two percent agreed that "Medicare is increasingly rejecting claims for medically appropriate services to save money." And 65 percent rejected the notion that "Medicare is doing a better job at reviewing the medical necessity of claims and is rightfully rejecting more claims because they are unnecessary."

This crisis in confidence increases costs and greatly hinders the effectiveness of utilization review, by resulting in growing numbers of requests for "fair hearings" and reconsiderations (28 percent of all respondents indicated they had requested hearings for claim denials during the past year); an unwillingness among physicians to become involved in so-called "peer review," due to a perception that such review is inevitably skewed toward reducing costs at the expense of quality; antagonism between the Medicare program and physicians and beneficiaries who suffer when claims are inappropriately denied; and unnecessarily obtrusive and excessive requirements for documentation of services rendered to patients. If, on the other hand, physicians generally found utilization review processes to be valid and the utilization screens medically appropriate, there would be greater compliance with the Medicare standards, fewer denials, and fewer requests for reconsiderations and fair hearings.

ASIM believes that one place to start instilling more confidence in the medical review procedures is to require carriers to consult with physicians regularly in developing their review programs. Although the new HCFA proposal that all carriers employ a physician to serve at least half time as a medical director is a step in the right direction, it falls far short of any requirement that carriers consult regularly with representatives of practicing physicians in developing their medical review programs, or that they utilize peer review when there are questions concerning the appropriateness of a particular claim determination. ASIM recommends that Congress direct HCFA to strengthen its requirements relating to consultations with professional organizations on the development of medical review criteria. Congress should also require that HCFA direct carriers to hire a full-time medical director.

ASIM commends HCFA for requiring carriers to provide physicians an additional opportunity to show that services were in fact medically necessary, prior to a contrary finding by the Medicare carrier. As of April 1, carriers must request additional information from physicians prior to deciding a claim for lack of medical necessity. This requirement is only in effect on a trial basis, however. ASIM urges Congress to require HCFA to make this a permanent change, so that physicians continue to have the opportunity to present documentation to show when services provided were in fact medically necessary.

ASIM agrees with the Commission's recommendation that more funding be directed toward medical review. We believe, however, that increased funding should be contingent on the development of more effective utilization review procedures rather than simply increasing the level and intensity of current review by the carriers. One strategy is a targeted approach that would monitor overall physician practice patterns to identify practice "outliers" that appear to be aberrant in comparison to those of their colleagues. Once identified, services provided by those physicians could be scrutinized by peer groups in far greater detail to determine if, in fact, the care provided to individual patients was medically appropriate. This approach would likely receive support from the medical profession and be more cost effective in the long run.

Over the long term, ASIM also urges Congress to examine the utilization review criteria and methods used by the private sector for their potential applicability to the Medicare program.

Conclusion

In conclusion, ASIM urges Congress to carefully review the recommendations of the Physician Payment Review Commission and take appropriate action to facilitate those recommendations. The Society strongly believes the Commission's major recommendation, that a national Medicare fee schedule be established based primarily on resource costs, deserves particular consideration, and urges Congress to reaffirm its support for this approach. Once the RBRVS is developed, Medicare will have for the first time a rational system of payment that will reduce the historical inequities in payment for cognitive and procedural services.

ASIM welcomes the opportunity to work with the Subcommittee in the future on this and other issues related to physician payment.

WALNUT 2-5252

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May 24, 1988

Congressman Fortney Stark, Chairman
Health Subcommittee, Committee on Ways and Means
United States House of Representatives
Washington, DC

Dear Mr. Chairman,

Re: Mandatory Assignment of Office Laboratory Charges.

This testimony is offered in response to your invitation related to the May 24, 1988 hearings of your subcommittee on the subject of Medicare Part B reimbursement policy. It is directed in particular to a provision of the December, 1987 budget reconciliation which has had consequences I presume the committee did not anticipate.

Interference with private options. The provision makes it an offense for a physician who does not participate in (or possibly even utilize) Medicare to bill a "Medicare eligible" person for laboratory services performed in the doctor's office. That is to say, charging for laboratory services has become a prohibited activity even between freely consenting persons, irrespective of financial means, merely because the patient happens to be over age 65. Since this is an amendment to the Medicare Act, it is particularly difficult to defend its reach to two parties in a transaction who take pains to avoid involvement of Medicare, through rejecting participation in the program, refusing the offer of assignment of benefits, and declining to take the option available to them of obtainng the service elsewhere without cost. However foolish their choices may seem to others, most Americans hotly defend their right to spend their own money as they choose. Indeed, the unique upopularity of taxes grows more out of their intrusiveness than their hardship.

Increased Billing and Claims Cost. However, the main point I wish to lay before Congress is related to the cost-escalating effect of a measure intended to save money. This seemingly simple provision has imposed a massive new accounting overhead cost on the physician, and an equally expensive complication of the claims processing of the fiscal intermediaries. When added to the earlier tortures of the MAAC program, it is entirely understandable that the Prudential Insurance Company has decided to withdraw from further service as a fiscal intermediary in New Jersey, North Carolina and Georgia. Other fiscal intermediaries are seriously concerned about employee morale and bad public image reflecting on their private business, as a result of the complaints and unmanageable policies imposed on them by annual Christmas surprises of the congressional budget reconciliation process.

Since splitting the services of one office visit to the doctor into two or more billing steps inevitably increases claims volume, resultant cost to the intermediaries will relentlessly find its way back to the Medicare budget. It will likely provoke alarm about the apparent increase in volume of services, since claims volume is the most speedily available surrogate for service volume. It will, no doubt, induce many physicians to refer patients to hospital out-patient laboratories where the charges are clearly higher in absolute terms, and the net revenue effect on the federal governnment must reflect the tax-exempt status of one type of vendor and the taxable status of the other.

It is difficult for physicians to measure the increased overhead cost of extra claims effort, since one ordinarily does not hire a fraction of an employee. It is easier to look back over the last ten years and see a truly important upward pressure on the cost of doing medical business, which such organizations as "Medical Economics" Magazine have documented clearly. Furthermore, new rules take time to move the system, and a better idea of the eventual impact of this rule on physicians can be gained by reviewing the remarkable jump in commercial laboratory charges in the time since they were required to bill Medicare directly, and hence incurred both administrative expenses and bad debt experience from which they had previously been shielded. While there were some reported abuses of the process of physicians subcontracting laboratory work, such could easily have been eliminated by fair handling and preparation charges, and in any event the scope of abuse could not possibly have equalled the cost escalation provoked by the direct-billing rule. (Please refer to the recent report of the United States General Accounting Office report GAO/HRD-88-32.) The 1987 rule will have the same effect in time, although some of it will be hidden in Medicare Part A as a result of physician referral to hospitals.

Increased Reconciliation Costs. Although your subcommittee includes some members who are former accountants, even they will probably feel their eyes glaze over when the subject of open-balance and open-item billing is mentioned. However, that is the issue which the apparently simple December 1987 prohibition on direct billing has created. Since the doctor who does not welcome the assignment of benefits must bill the patient for office services and also bill Medicare for the office laboratory services, he must find a way to keep the payments separate. That is, instead of merely keeping a running balance of unpaid receivables, he must identify the items and check off each one individually as payment is, or is not, received. Any doctor who uses any sort of assignment process must employ more highly trained employees to cope with the complexity, amd hire more of them. He must accept the likelihood of more error, hence lower income. His costs will rise, and inevitably costs to the program will follow.

Mr. Chairman, during the introduction to one of last year's hearings on this subject, you announced your wish to induce physicians to join the Medicare participation program by simplifying their overhead. In that spirit it would be proper for the government to put itself to extra trouble and expense in order to make things easier for a participating physician. However, once that motivation is announced, it is of increased importance to avoid actions which might give the impression of attempting to coerce unwilling physicians by unnecessarily disrupting their affairs. I am sure you agree with this viewpoint, and urge you to reconsider the office laboratory billing prohibition.

Respectfully submitted,

George Ross Fisher

George Ross Fisher, M.D.

GRF/gj

STATEMENT OF RICHARD V. GRANT
EXECUTIVE DIRECTOR
MEDICAL GROUP MANAGEMENT ASSOCIATION

The Medical Group Management Association (MGMA) is pleased to present its views on the second annual report of the Physician Payment Review Commission (PPRC). Representing over 3,500 medical groups, MGMA is very interested in the PPRC's work on reforming the physician payment system under Medicare.

(MGMA's research affiliate, the Center for Research in Ambulatory Health Care Administration (CRAHCA) provides much of the data used to support MGMA's position on various payment reform options.)

MGMA member groups represent a broad spectrum of medical care providers, including large multispecialty groups, academic practice plans associated with teaching hospitals, groups that contract with HMOs, and single specialty groups. As a national professional association, MGMA represents group practices in urban as well as rural areas.

Any reform of the Medicare Part B payment system will affect the majority of our membership. Our interests, as well as those of the Medicare beneficiaries, will best be served if the payment system is reformed so that it reimburses physicians fairly and equitably.

A National Fee Schedule

The trend in physician payment reform seems to be leading us to a national fee schedule. The work of the Harvard University researchers on developing a relative value scale, if implemented, will undoubtedly result in drastic changes to the way physicians are currently paid under Medicare. Two areas with respect to national fee schedules are of particular concern to MGMA.

First, any change from the current payment system to a national fee schedule should be undertaken with a gradual transition period that would allow for an appropriate adjustment time. For example, Medicare rates might be a blend of the national rates and the physician's customary rates for the first few years, and gradually move to fully national rates after three or four years. The hospital prospective payment system was implemented this way, and although the transition was still difficult for some hospitals, it was far better to make the change gradually.

Fees will have to be updated annually to account for increases in the cost of practice. Whatever method is used to update fees, it should not be used in policy making as a tool to save money out of the Medicare budget.

If a national fee schedule were implemented that paid all providers the same rate for the same procedure code across all specialties and all geographic areas, it would unfairly penalize those physicians in geographic areas with a higher cost of practice.

To be equitable, a national fee schedule would have to make adjustments for physicians practicing in areas where costs are higher. It would also have to make adjustments for specialists who have a higher cost of practice for reasons other than their geographic location. For example, a neurologist and a general practitioner, both bill under the same procedure code for an office visit; however, the neurologist usually charges a higher fee because that type of an office visit would probably include more services. Board-certified specialists have more training and often use more sophisticated equipment than general practitioners, and their fees ought to be adjusted accordingly.

For the past several years, CRAHCA has compiled cost data from MGMA member groups and published the results annually in the "Cost and Production Survey." The data could be used in the development of a "cost of practice index," discussed in Chapter 7 of the PPRC report. MGMA would be happy to work with the Subcommittee and its staff in developing a cost of practice index.

Physician Participation in Medicare

As the PPRC stated in Chapter 10 of its report, there are several options that could be considered in helping to raise participation rates. MGMA feels strongly that any plan that is implemented to encourage physician participation in Medicare should reward physicians for participating, and minimize penalties for non-participating physicians.

Many of the "incentives" in the current program are not true bonuses--they are designed so that it becomes administratively burdensome for physicians not to participate.

Statistics indicate that the current voluntary program is working quite well. Based on a recent MGMA survey, as of May 1, 1986, 31 percent of MGMA member groups fully participated in the Medicare program by signing participation agreements, and another 60 percent accepted assignment on a case-by-case basis. MGMA feels strongly that participation in the Medicare program should be a voluntary decision. Any attempt to mandate assignment under the Medicare program would unfairly restrict both the providers' and the beneficiaries' options.

Reform of CPT-4 Coding

MGMA feels strongly that the system of coding under Medicare (CPT-4 coding system) would benefit from some simplification. However, reducing the number of CPT-4 codes from the current 7,000 is not an easy task, and if a simpler system is developed, it should be implemented with adequate lead time, so as to avoid the confusion that normally accompanies drastic reform of a system.

Developing a "multi-physician package" for surgery would be a good starting point in experimenting with such a concept. (MGMA) would be happy to assist in identifying multispecialty groups that would be willing to participate in a demonstration project.) On an experimental basis, a multispecialty group practice would be a likely setting in which to test the concept. In a group practice, payment could be made to the group for the surgical package, and the group could then decide which physicians would be paid and how much each physician would receive.

Because a multispecialty group is likely to employ all the necessary specialists needed, i.e., radiologists, surgeons, pathologists, internists, etc, the risks of financial disincentives for surgeons to utilize the expertise of the other specialists is minimal.

A multispecialty group practice is an ideal setting to experiment with a global payment system. In most cases it would not be necessary to limit the global service to include only the services of the responsible physician, though it probably would be necessary if the surgeon were a solo practitioner. If all the specialists are employees of the group, there is no "fee-splitting" involved in distributing payment for bundled surgical services.

Some of the larger multispecialty group practices within MGMA are already experimenting with such a concept.

We invite the Subcommittee to investigate some of the work that our Center for Research has done in using the CPT-4 coding system to document physician practice patterns. CRAHCA developed a computer software program that documents physician practice activity by CPT-4 codes. Each procedure is then assigned a relative value. Reports generated by the software enable physicians to analyze the intensity of their practices (average relative value per patient for a given time period) and the complexity of their practices (average relative value per procedure).

The relative value scale has four major sections, medicine, surgery, pathology, and radiology. Actual specialty differentials are accounted for by different codes. If the same procedure is performed by different specialists, there is one code across specialties with one relative value.

Some of MGMA's member administrators are working with physician specialty committees to estimate resource consumption standards for units of service (bundled services). The CRAHCA software system can be used to examine physician profiles, particularly in regard to individual or bundled services.

This information could be useful in developing a demonstration project to test the use of a global payment system.

Improving Utilization Review in Medicare

Undoubtedly, the utilization review system currently in place in the Medicare program would benefit from some refinements. The system in place now uses a computer system to determine how closely a particular claim adheres to the established screen for a given medical situation. If the computer rejects the claim for being "medically unnecessary" or not following the screen, then the physician or beneficiary automatically receives a rejection notice. The physician and/or beneficiary is therefore forced into the appeals process, even though the claim was only examined by a computer, not a medical professional or claims specialist in the carrier's office.

Another problem with the current utilization review system is the lack of communication between the provider and the carrier regarding what procedures are within the screen, and what documentation is needed to prove medical necessity when the provider's services are outside the screen. Too often, a provider receives a rejection notice that asks for additional documentation, but does not specify what is needed to successfully support the claim.

MGMA would like to see more opportunity for involvement in developing these screens. Medical specialty experts and professional peer review organizations (PROs) should have significant input when screens are developed. Because these screens play such an important role in utilization review, we feel it would be more appropriate for the screens to be developed through a formal rulemaking process, where a proposal is published in the Federal Register and there is an opportunity for public comment.

Increased funding for the carriers would probably improve utilization review, especially if it would allow the carriers to employ or contract with physician reviewers. MGMA believes it is inappropriate for non-physician personnel to review claims for medical necessity.

Conclusion

We hope that our comments have provided some insight into yet another aspect of the medical profession and our interests in the reform of Medicare's Part B payment system. We would be happy to provide to the Subcommittee members and staff any supporting, or research material we have compiled in any of the areas mentioned in our statement.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

My name is James Roosevelt and I chair the National Committee to Preserve Social Security and Medicare. The National Committee has more than five million members and supporters, the majority of whom are Medicare beneficiaries. As a consequence, they are deeply concerned about rising health care costs. Our members remind us daily about the failure to contain health care costs and the struggle they face to make ends meet. The pain resulting from this January's 38.5 percent Part B premium increase has not yet subsided.

In a recent survey of National Committee members, an overwhelming 72 percent of respondents agreed the federal government should regulate doctors' and hospital fees. Two-thirds of the membership ranked, as one of their top two priorities, that doctors be required to accept assignment. Controlling premium increases was also a high priority.

In response to the 38.5 percent premium increase, Congress promised last year to reform physician payments. But another year has almost passed. Physician payment reform is still somewhere down the road and Congress has yet to protect seniors from out-of-pocket medical care costs. There was little effort to stop the $6.90 monthly Medicare premium increase effective last January, and extended for another year is beneficiaries' 25 percent share of program costs. Without this deliberate legislative action, the law would have reverted back to capping premium increases to the cost-of-living adjustment (COLA) beginning in 1989.

Congress complains about the costs of Medicare Part B and doctors complain about unfair Medicare payments. But tieing premium increases to program costs and voluntary assignment permits Congress to pass the costs of the current Medicare payment system on to beneficiaries and doctors to pass on higher fees to some extent. This reduces the incentive of Congress and doctors to be committed to physician payment reform.

> **The National Committee strongly endorses physician payment reform, but physician payment reform alone should not be relied on to protect beneficiaries from out- of-pocket costs. Therefore, the National Committee also recommends capping premium increases to the Social Security COLA and mandatory assignment.**

Physician Payment Reform

The Physician Payment Review Commission has recommended that Medicare adopt a relative value scale. While not the only possible payment reform, a relative value scale has potential to reduce overall program costs and make the payment system fairer.

After the recent experience of quality care problems with Medicare's hospital cost containment program, beneficiaries worry about the impact of physician payment reform on quality. Capitation and DRG's as physician payment reform alternatives have more potential for quality care problems than a relative value scale. A relative value scale may even improve quality by increasing payments to primary care physicians who generally have the most extensive and direct contact with their patients, but who have the lowest income among Medicare doctors. Average annual income for general family practioners was $80,300 in 1986 compared to the overall average of $119,500.

Medicare Premium Increases

Medicare Part B program costs have steadily increased at the average rate of 18 percent a year over the last decade and indications are that this trend is continuing. Unless Congress acts to protect beneficiaries they will again be subject to a substantial premium increase next January. The Health Care Financing Administration estimates the premium will increase from $24.80 to $28.00 next January. This would be a 12.9% increase and is 60 percent higher than the $2.00 increase that Congress considered reasonable at the end of last year. When the final increase is determined, the premium increase will probably be even higher. The Conference Report of last year's Omnibus Budget Reconciliation Act committed Congress to review the HCFA premium increase if it was higher than $2.00 a month.

Our members are deeply concerned about the ever-increasing premiums. One National Committee member, Virginia Robert from Mira Loma, California, writes, "Something must be done soon to improve Medicare coverage and to stop the increases in premiums. We seniors cannot absorb any more increases. Our rent goes up, our insurance goes up, our food goes up and any Social Security increase is eaten up many times over. Most of us barely exist." Another member, Dale Priest from Austin, Texas, states, "They are taking out so much now from our Social Security that any more reductions will cause considerable hardship for people like us with very limited income outside of Social Security." Ruth Fisher of Charlotte, North Carolina, laments, "I am wondering if you ever realize how hard it is to live on less than $4,000 a year. . . We cannot afford another raise in Medicare."

Mandatory Assignment

After three years the Participating Physician Program has failed to convince 70 percent of doctors to accept the Medicare-approved charge as full payment for all patients and there is little reason to expect the percentage to increase significantly. While the overall assignment rate has increased, there are significant variations in assignment rates by geographic location, by specialty, by type of service and setting of service. This means that some seniors have better access to physicians who will accept assignment than do others. And even when a beneficiary chooses a primary care physician who accepts assignment, the senior frequently has little control over the specialists to whom he or she is referred.

By increasing fees for primary care physicians, relative value scale may increase the participation rates of general and family practitioners who have only a 25.6 percent and 27.1 percent rate of participation currently. But the weakness of the voluntary program is that the relatively high participation rates for radiologists, pathologists and surgeons (39.5, 37.7, 37.2) are likely to decline if the relative value scale reduces their fees as it is likely to do.

The Physician Payment Review Commission reports that in 1987 doctors charged beneficiaries between $2.5 and $3.1 billion in additional charges or about $82 to $100 per beneficiary. Beneficiaries who patronize nonparticipating doctors who will not accept assignment must pay an average of 40 to 50 percent of the bill compared to the 20 percent paid by beneficiaries who use participating doctors. Seniors are already paying an average of over $2,100 annually in out-of-pocket health care expenses and many can ill afford to pay the additional doctor charges.

The expense of balance billing can keep seniors from seeking medical attention when it is warranted. We frequently hear from seniors who cancel doctors' appointments because they cannot afford what it costs. As stated in the Physician Payment Review Commission report, if physicians who accept assignment are readily available, beneficiaries are less likely to avoid or postpone care for fear of large, unpredictable out-of-pocket costs. Balance billing causes hardship for many beneficiaries even if they have private insurance to supplement Medicare, because few medigap insurance plans cover more than the 20 percent copayment.

Another important aspect of doctors accepting assignment in the Medicare program is the simplification of paperwork. Participating doctors bill Medicare directly and follow up with necessary reconsiderations or appeals. These processes tend to be confusing and taxing on seniors. One member from Placerville, California, illustrates well the burden of balance billing, "I lie here at home in a hospital bed, in shock, facing the fact that in all cases where assignment was not taken by a doctor or a lab, Medicare approved less than half, and paid 80 percent of that amount; in some cases they flatly disallowed any payment for what appeared to be legitimate charges. I know I may appeal, but am too ill to do so, since my condition has worsened since I returned home."

More and more beneficiaries are aware of the difference between participating and nonparticipating doctors. However, it is not always easy for seniors to switch to a particpating doctor if they have patronized a doctor who refuses to take assignment. Going to any doctor can be anxiety provoking for seniors; going to a new doctor only increases this anxiety.

Conclusion

Since the inception of the Medicare program and up until very recently, doctors have set their own prices for services. They continue to be free to decide whether they want to accept Medicare assignment and whatever the doctor decides, the beneficiary pays. The status quo will be a disaster for beneficiaries and Medicare.

THANK YOU.

STATEMENT OF THE
NORTH AMERICAN SOCIETY OF PACING AND ELECTROPHYSIOLOGY

NASPE (the North American Society of Pacing and Electrophysiology) is a 900 member professional medical specialty organization of physicians and technically-oriented personnel with a primary interest in cardiac pacing, cardioversion/defibrillation and electrophysiology. Its purposes are to advance the state of knowledge of cardiac stimulation and the normal electrophysiology of conduction and impulse formation; to study the causes and mechanisms of supraventricular and ventricular arrhythmias and the means of management of those conditions, which collectively have been a major cause of disease and death. The members of NASPE have collectively been involved in major and historic contributions to this field involving basic science, and clinical application. This includes the performance and interpretation of electrophysiologic testing and the physiologic specifications of implantable devices such as cardiac pacemakers and cardioverter/defibrillators. NASPE has a strong program concerning the presentation of new and review information to the profession and of fostering the education of young physicians.

As a result of conditions which are congenital or of obscure cause and for which specific treatment remains unknown and as a result of other conditions such as arteriosclerotic cardiovascular disease, the heart rate may be too slow, too rapid or irregular and result in severe disability and, commonly, death. Such irregularity usually results from a lack of normal conduction between the heart's chambers or from an independent and erratic beating of the major, life sustaining, pumping chambers, the ventricles. Electrical stimulation, delivered by a cardiac pacemaker can restore the heart's regularity either episodically or for very prolonged periods, ie years and decades.

There are two types of cardiac pacemakers, single and dual chamber. Single chamber devices sense and pace only one of the heart's chambers while the dual chamber devices pace and sense the upper and lower chambers. They are the most sophisticated devices available and can approximate normal heart function. These devices have resulted from an intensive and prolonged development process extending, over a quarter century, from devices which functioned for six months and stimulated the heart at a fixed, invariable rate maintaining the lack of communication between the heart chambers. Present day devices can function, without replacement, for a decade and more and can restore the normal functioning of the heart and even add to it by sensing body functions previously unused, to determine the appropriate heart rate and even be "smarter" than the body itself. These devices operate automatically but require careful implantation technique and post implantation "programming" to set the proper level of function and sensitivity to body function. In order to achieve the capability of present day devices, intensive post implant electronic manipulation is required.

It is estimated that in 1985, 86,000 persons received initial pacemaker implants in the United States. Seventy-nine percent of these were of Medicare age, fifteen percent were younger adults, between fifty and sixty-four years of age, six percent are children or younger adults. For the majority of these patients implantation of a pacemaker is a new lease on life, for a very large group it is life saving. For others it relieves disability and returns them to level of health and activity compatible with other health conditions. Following pacemaker implantation, patients previously subject to fainting episodes and the threat of death can drive a car, care for themselves and engage in sports. In short, the availability of pacemaking technology has meant prolongation of useful and quality life for hundreds to thousands of Americans.

In spite of the acknowledged life-giving and life-enhancing qualities of pacemaker technology, there has been considerable controversy in recent years about the cost of pacemaker implantation to the Medicare program. Allegations of overutilization and overvaluation have surfaced from several quarters. Although we acknowledge that, as in all areas of human endeavor, mistakes and abuses may have occurred, many have been exaggerated from the start and others have been corrected.

Recent development concerning pacemaker practice was the "DEFRA Report to the Congress on Pacemaker Surgeries", prepared by the Secretary of Health and Human Services in accordance with Section 2304 (b)(1) of P.L. 98-369. This study, released last December, purports to show that the time involved in performing pacemaker implantations has decreased by one-third between 1967 and 1984, while charges for these procedures have generally kept pace with medical care inflation.

NASPE has serious concerns about the methodology of the DEFRA report. The report itself acknowledges that it is based on a "relatively small number of observations", about the actual duration of pacemaker implantations in 1967. It appears that only 33 cases were available for study from 1967 and that, of these, only 13 had been implanted transvenously, the method used in virtually all implants today. In addition, the comparisons of pacemaker implants in 1967 with those performed in 1984 is between two different technologies and unless carefully scrutinized and evaluated may allow spurious conclusions. The methods of implantation and the technologies have changed dramatically between 1967 and 1984. The DEFRA report also states that it is unclear whether physicians now spend more time with pacemaker recipients outside the operating room than was the case in 1967. Indeed, that is an important consideration. Pacemakers implanted in 1967 could not be adjusted either before or after implantation. That is not the case at present. Pacemakers today allow for immense adjustment in capability after implantation. This is especially true for the dual chamber and rate modulated pacemakers which now account for about half of all those implanted. "Programming", ie the non-invasive adjustment of the pacemaker to patient needs can take as long or longer than the operative procedure itself and is the physician's responsibility.

If time expended is the measure of effort, little time reduction has occurred in the act of implantation. Dual lead systems, requiring the placement of two electrodes are in use in about one third of all patients. These are far preferable to single chamber implants and require much more time. Unless these have been specifically evaluated in the calculation of "effort" then the data determined is clearly incorrect.

Even if one were to concede (and that would be an error) that the time involved in the surgical procedure of pacemaker implantation has declined, this should not, inevitably, lead to the conclusion that the procedure is less valuable today than in 1967. There are factors other than surgical time which must be considered in evaluating a medical procedure. Among these are the complexity of the procedure, the amount of physician training involved, the patient counseling, and others. Clearly, the modern pacemaker is for more complex and sophisticated than its predecessors in the 1960's and the level of skill needed to implant and maintain it has increased accordingly.

We think there is need for periodic reevaluation of payment rates for medical procedures. If medicare is expected to pay for technological breakthroughs that prolong and improve the quality of life, the system should also be allowed to benefit when experience and technology render a procedure less costly to perform. Conceivably, the Harvard/AMA Resource Based Relative Value Scale, now under development, could assist in maintaining the validity of charges if a periodic reassessment of the resources expended in providing specified services were instituted.

Allegations that there has been excessive prescription of cardiac pacemaker devices for symptoms of uncertain or unsubstantiated cause have appeared in several medical and/or lay publications in recent years. In particular, a recent article by Greenspan et al (New England Journal of Medicine, January, 1988) has been widely quoted as supportive evidence that, of pacemaker cases performed in Philadelphia during 1983, only 44% of procedures were felt to be definitely indicated, 36% possibly indicated and 20% not indicated by reference to criteria established subsequently and without the knowledge of the implanting physician. This type of "hindsight" science represents a form of Monday morning quarterbacking in which knowledge gleaned during succeeding years is applied to past practices that are now deemed inappropriate. In fact, the requirement that all Medicare recipients of cardiac pacemakers receive pre-operative, pre-procedural approval from local PRO's ensures that the incidence of inappropriate or unwarranted pacemaker cases is currently less than 1% in many states. The Philadelphia study involved cases that were performed prior to dissemination of any published guidelines for pacemaker implantation and it is not surprising that the implanting physicians failed to meet the proposed criteria which had not been shared with them in advance of their decision-making process. It seems unreasonable to hold physicians retroactively to newly-established standards which had not been promulgated at the time.

Cardiac pacemaker implantation has seemingly become the "whipping boy" of Congressional and fiscal review committees in recent years. Documented instances of fraudulent behavior abetted by overzealous sales tactics by manufacturers representatives have been an embarrassment to the vast majority of physicians and manufacturers who decry such practices.

Cardiac pacemakers represent one of the most extraordinary innovations in medicine in the last fifty years. A majority of pacemaker recipients are over 65 and prescribing physicians are required by law as well as common sense to prescribe them judiciously. We think recent federal policy regarding pacemaker implantation has been based on misinformation, innuendo, and an unwarranted lack of faith in the life-saving and enhancing qualities of this technology. We hope that by this statement, NASPE and the Congress may begin a dialogue which will lead to new understanding of the importance to our nation's elderly of the availability of cardiac pacemakers. On our part, we pledge to renew our efforts to weed out the unethical practitioners, to shun the improper sales tacticians, and to guarantee to all our citizens the highest quality medical care possible.

Thank you for the opportunity to make this statement. We sincerely look forward to working with the subcommittee toward our common goal of providing life-sustaining and enhancing care for the American people in a thoughtful, caring and selfless manner.

Pennsylvania Society of
Gastroenterology
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June 20, 1988

The Honorable Fortney Stark, Chairman
Subcommittee on Health, Ways and Means Committee
1125 Longworth House Office Building
U.S. House of Representatives
Washington DC 20515

RE: Testimony of Mark R. Chassen, M.D., M.P.P., M.P.H. Concerning Payment of Physicians by the Medicare Program, on May 24th.

Dear Congressman Stark:

The Pennsylvania Society of Gastroenterology would like to comment on the statement submitted by Dr. Chassen, specifically, as it relates to their study concerning upper gastrointestinal endoscopy and generically concerning the methodology of assessing appropriateness. We would like to have your committee consider the rather considerable difficulty the Rand group had in developing their appropriateness scale for indications.[1] They chose nine experts who use endoscopy in their practice and mailed them selected literature reviews with their rating sheets. Despite this "program" the nine agreed on less than 17% of indications and seven of the nine agreed on less than 30%. Indeed, they disagreed markedly in 38% and significantly in 63%. Clearly then, what one calls inappropriate might well be appropriate to another. To try to improve the agreement the Rand group brought the nine panelists together for a one day discussion session in which they re-rated the indications. Following this there was agreement of all nine in about 25% and disagreement dropped to 48% (still quite significant). Please notice that two of the nine experts could have felt a procedure was highly appropriate and it still be listed as inappropriate with "agreement". The fact that there was pressure during the day is evidenced by the fact that of the three procedures to be discussed, one, colonoscopy, could not be considered due to time constraints. This procedure, colonoscopy, had only 1.8% agreement before and 2.6% agreement after a second mailing and therefore had to be excluded from the study. This would suggest that better agreement between nine experts can be reached if they can discuss the indications in depth together. Obviously, this is not available to the individual physician seeing patients and trying to decide the appropriateness of any given procedure.

It would be quite interesting to see if another nine experts would come up with the same list.

Considering the process by which the determination of appropriate or inappropriate was arrived at, it would seem unlikely that those procedures called inappropriate would be so designated in true peer review. In an attempt to control costs, efforts are being expended to try to standardize and regulate an extremely variable process. While the goal of determining in advance the proper decision process and outcome for any given health problem might be laudable, clearly the information base is totally inadequate now and in the foreseeable future to accomplish this.[2]

Specific comments concerning Dr. Chassen's testimony are directed to the first paragraph on page 5 with regard to using endoscopy to document the presence of a duodenal ulcer within two weeks of an x-ray, I would suggest that there are definite clinical indications for such a process. Clearly, if the patient is still symptomatic in spite of appropriate treatment program, it would be appropriate in light of the fact that radiology assessment of duodenal ulcers is frequently erroneous. On page 6 of his presentation the first paragraph is quite correct. As a screening technique this may have been the best available criteria; however, it certainly can not be used as proof of inappropriateness. Accordingly, the statement in the second paragraph alleging the ability to discover specific quality of care problems and assess their magnitude is quite wrong. It would seem much more proper to take those procedures that were deemed "inappropriate" and submit them to true peer review before making such statements. We would suggest that only through peer review of the individual case can appropriateness be dterminted.

I appreciate the opportunity of submitting this information for your consideration.

Respectfully,

William H Mahood

William. H. Mahood, M.D., Past President Pennsylvania Society of Gastroenterology
Chairman Liaison Committee

1. Park, R E, et al: Physician Ratings of Appropriate Indications for Six Medical and Surgical Procedures; American Journal Public Health 76:766,1986.
2. Fink A, et al: Sufficiency of Clinical Literature on the Appropriate Uses of Six Medical and Surgical Procedures; Western Journal of Medicine 147: 609, 1987.